Department of Veterans Affairs

Palo Alto Health Care System

FY 2000-2002
Strategic Plan

VA PAHCS
Veterans Affairs Palo Alto Health Care System
EXCELLENCE BY DESIGN

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DRAFT –
Working Document

Table of Contents

Executive Summary

- Section 1

The VAPAHCS' strategic plan identifies priorities and action for fiscal years 2000 through 2002. Our priorities reflect the priorities of the Department of Veterans Affairs (DVA), the Veterans Health Administration (VHA) and the Sierra Pacific Network (VISN 21).

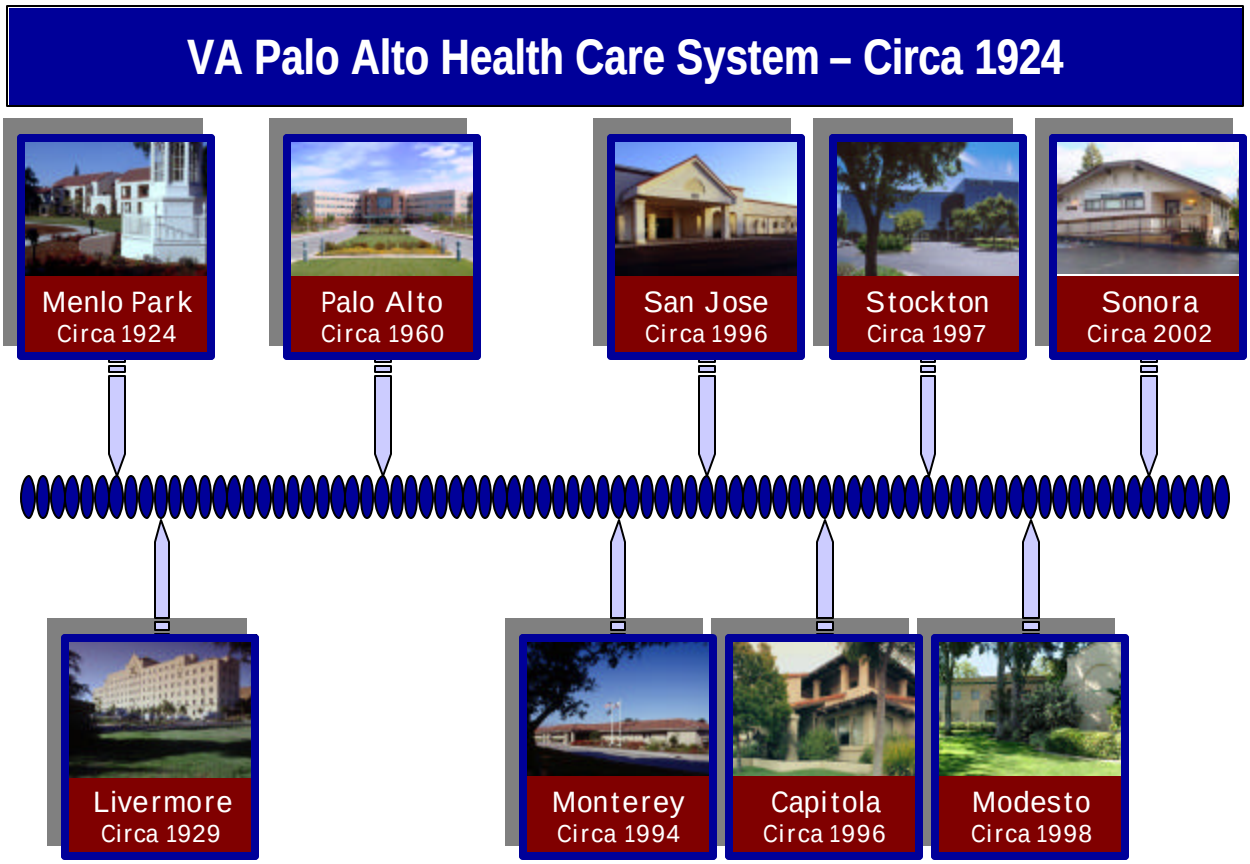
The primary goal of VAPAHCS is to further enhance our development of an integrated health care system that anticipates and meets the clinical needs of the veterans we serve.

To best achieve this goal, we have examined our strengths, weaknesses and position within VHA, VISN 21, our regional referral networks and the local communities in our catchment or Primary Service Area (PSA). This analysis confirms VAPAHCS is a standard bearer for tertiary referral centers. Our future goals will be to:

- Refine our clinical services and treatment programs
- Improve the quality of care delivered
- Enhance special emphasis programs
- Improve customer service
- Instill a sense of cohesiveness and self worth among our staff

We anticipate that the VAPAHCS will face significant financial challenges in the coming years. A significant challenge is the need to improve our business processes, the most important of which is our ability to effectively and efficiently collect payments from first and third party payers. We must also secure sufficient capital funding to ensure that our many buildings are seismically safe and provide an environment of care in which we may all take pride. We must ensure that our employees have the tools and training they need to do the work we expect of them. Finally, we must provide them with compensation and recognition for a job well done.

The VAPAHCS has established this strategic plan as a management tool for addressing our priorities. The strategic plan serves as a roadmap to the future. It is based on a foundation of commitment to excellence, accessibility, service and value.



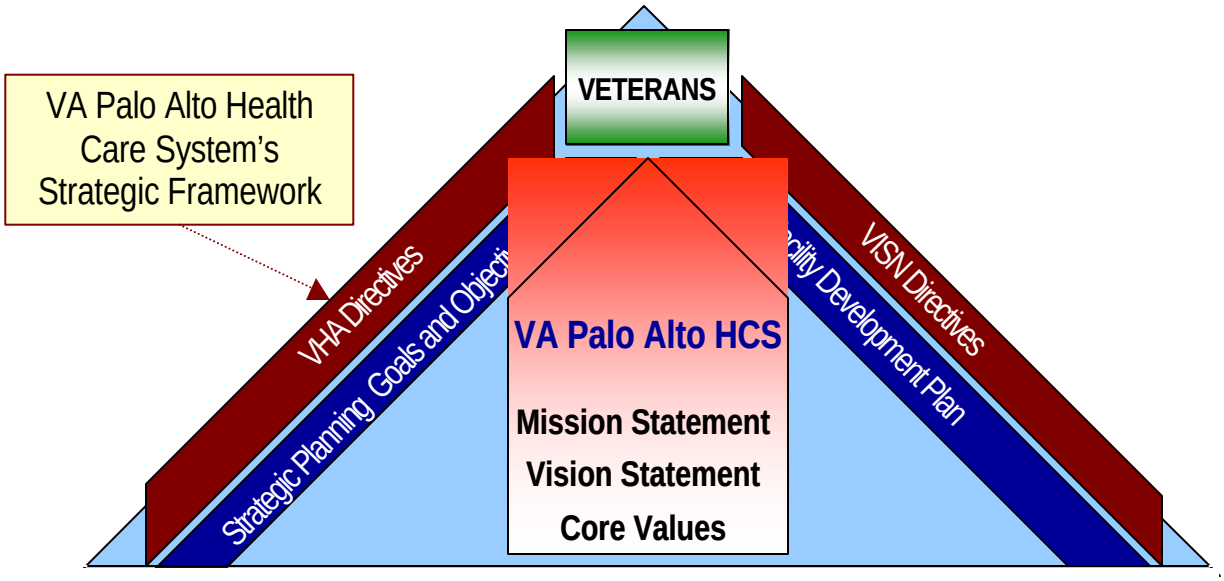
Strategic Planning Framework

- Section 2: Mission, Vision, Core Values

Like VHA and VISN 21, VAPAHCS has embarked on a *"Journey of Change."* The course we have chosen reflects the goals of VA, VHA and VISN 21. The goals, objectives and tactical actions reflected in this plan are designed to achieve a service oriented, user friendly, efficient, results-driven health care organization.

The VAPAHCS' mission statement describes the fundamental purpose of our organization: *PLACING VETERANS FIRST!*

Mission Statement:	*The mission of the VA Palo Alto Health Care System is to serve the veteran through compassionate, innovative, comprehensive, accessible quality patient care in a safe and supportive environment while promoting excellence in research and education*
Vision Statement:	*The VA Palo Alto Health Care System will provide veterans and others whom we serve with an efficient, integrated system of patient care; will be a valued community resource; an employer of choice; and an international leader in research and education*
Core Values:	*Trust, respect, excellence, commitment and compassion*



Strategic Planning Framework (cont'd)

- Section 2: Organization Structure

The VAPAHCS utilizes a traditional organization structure in which the Chief of Staff and Associate Director for Administration report to the Director. The organization design is seamless; all clinical departments report to the Chief of Staff while all administrative departments report to the Associate Director. There are five exceptions: Communications, Compliance, Equal Employment Opportunity, Facility Planning, and Quality Management. These functions report directly to the Director. The VAPAHCS' organization framework is depicted in the wire diagram below.

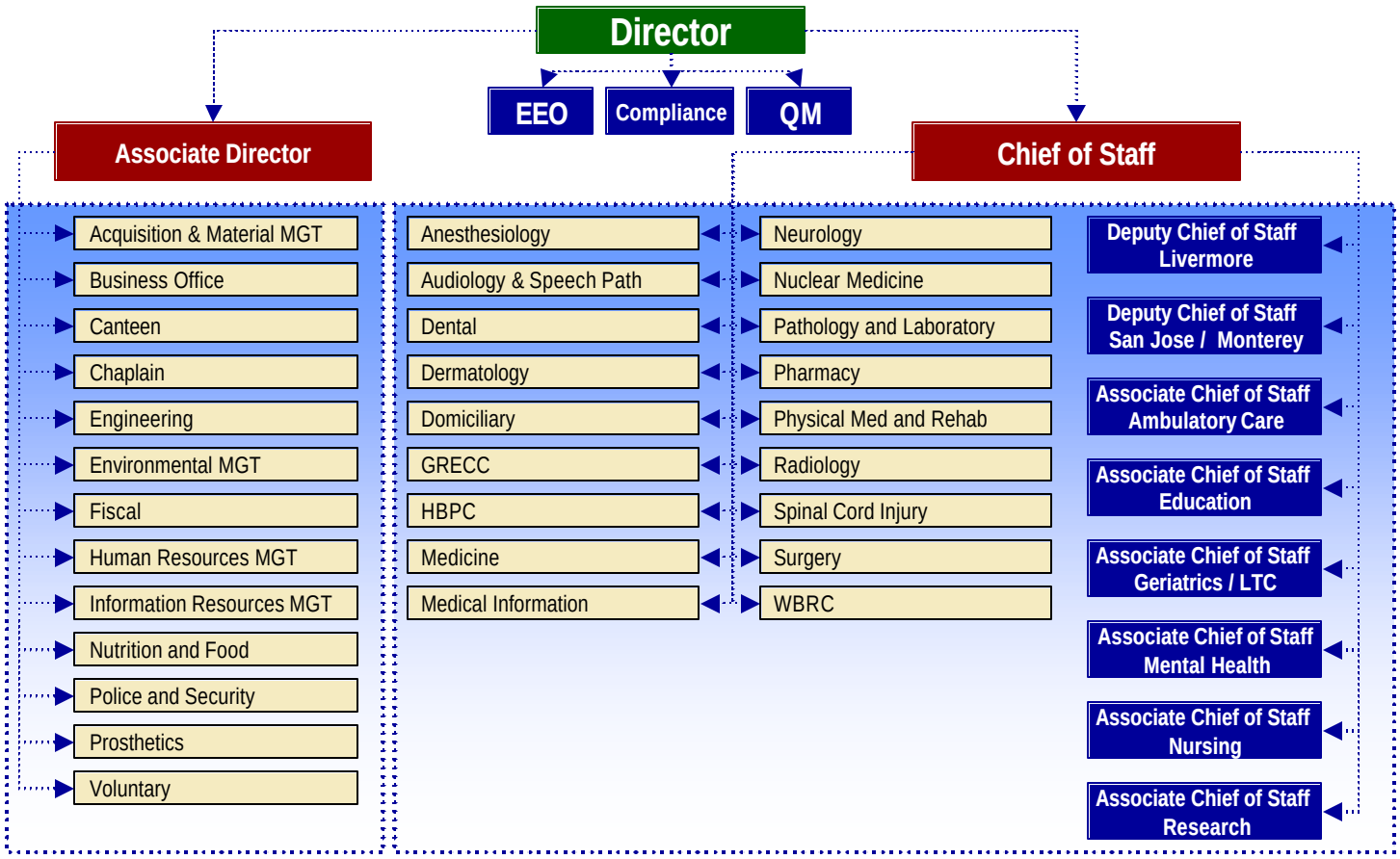
In FY02, the Veterans Health Administration (VHA) will re-title the following positions in order to effectively align these executives with their civilian counterparts. Their functions, however, will remain the same. The current and future position titles are as follows:

Director……..Chief Executive Officer (CEO)

Associate Director……..Chief Operating Officer (COO)

Chief of Staff……..Senior Vice President for Clinical Services (Senior VP – Clinical Services)

VA Palo Alto Health Care System – Organizational Chart



Strategic Planning Framework (cont'd)

- Section 2: Strategic Planning Process

In prior years, the Strategic Planning Process for the VAPAHCS was conducted and managed principally at the VISN level. [At the Region level prior to the establishment of the Sierra Pacific Network (VISN 21)]. Accordingly, the goals and objectives of the Network were adopted as the strategic planning framework for facility level planning. Locally, committees, task groups and service chiefs have been charged, as appropriate, with the responsibility for developing performance improvement plans for implementing the Network's goals and objectives. The most significant of these has been the Executive Council which is the principal policy and planning board for VAPAHCS, the Quality Leadership Team (QLT) which has developed an annual QLT Plan and the Executive Resources Board, which develops the Health Care System's financial plans. In addition, VAPAHCS has a separate Facility Development Plan, which has served well as a guide for capital facilities development (construction) and space utilization. Further, major equipment procurement plans and education plans have been developed annually to meet the needs of our organization.

In recognizing the need to integrate these diverse planning tools more effectively, a facility Strategic Planning Group was formed in April 1999. The Strategic Planning Group is chaired by the Director and includes the following members of our executive leadership team:

Strategic Planning Group

- Director (Chair)
- Associate Director
- Chief of Staff
- Deputy Chief of Staff, LMD
- ACOS – Ambulatory Care
- ACOS - Extended Care
- ACOS – Mental Health
- ACOS - Nursing
- Chief, Quality Management
- Chief, Medical Services
- Chief, Surgical Services
- Chief, Decision Support System
- Facility Planner
- President, AFGE Local 2110
- President AFGE Local 1620

The Strategic Planning Group met on a monthly basis to formulate the strategic plan for FY 2000 - 2002. Using organizational performance data, the planning group conducted an assessment of organizational strengths and weaknesses and identified factors that influenced its strategic directions. Planning assumptions were then developed through a consensus process to define the expected budgetary, capital asset and political boundaries for planning. Organizational priorities for improvement were defined and tested against the National and Network strategic planning goals and strategies for consistency. These priorities were synthesized into six strategic goals that define the key organizational planning priorities at VAPAHCS for FY 2000 - 2002.

The ultimate goal of the Strategic Planning Group is to involve as many employees as possible in the development and implementation of our Strategic Plan. The following stakeholders were provided a draft of the Strategic Plan in January 2000:

Veterans Service Organizations
Academic Affiliate
Employees
Service Chiefs
Unions

On May 2000, we convened all clinical and administrative service chiefs and other key VAPAHCS leaders and Union representatives in a retreat. One action was to make final revisions to the proposed goals, strategies and tactical actions defined in Chapter X; these revisions have been incorporated into this final version.

Strategic Planning Framework (cont'd)

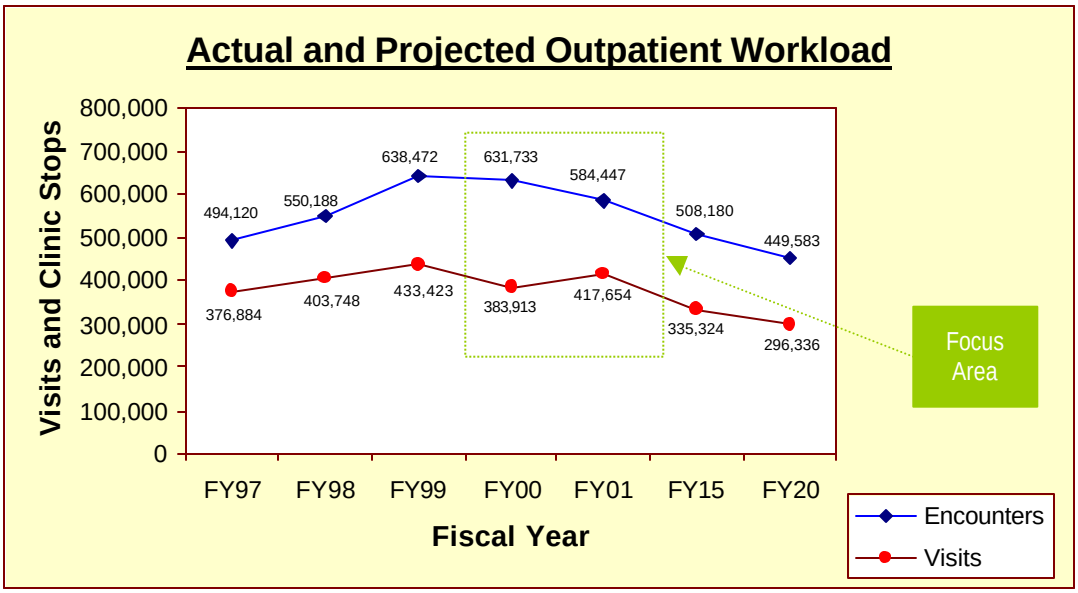
- Section 2: Actuarial Data to Help Define and Understand Future Demand for Services

The VAPAHCS' strategic planning framework is a critical pathway because tomorrow's success will depend on the decisions that we make and execute today. Undoubtedly, the strategic planning framework that we develop and implement today will impact staffing, the provision of care, expansion and consolidation decisions over the next ten to twenty years. Understanding demographic information, veteran enrollment statistics, population predictions, and demand for services, over an extended time horizon, will ultimately impact on how we, as an organization, conduct business. If we fail to make accurate decisions, based on the knowledge that we have available to us today, we might adversely impact the provision of patient care for years to come.

Economists, statisticians, and actuaries attempt to determine future enrollment statistics utilizing veteran population models that incorporate life expectancy and migration patterns. The VA utilizes current demographics to help explain where veteran populations will migrate over the next 30 years. In an attempt to effectively fund capital projects and future expansion efforts, these population predictions will be key to the VA's future. Formulating appropriate and rational decisions with regard to financial resource allocation will be critical because capital resources are limited; the wrong decisions will lead to misallocation of scarce resources and will ultimately misalign the medical care that we offer our veterans.

Accurate and reasonable planning assumptions are critical to developing realistic statistical planning models. These models will be used to explain the anticipated future demand for clinical and inpatient services. The Planning Systems Support Group in Gainesville, FL completed the following v00 planning model depicted below. Modeling is not a science, rather these statistical techniques are utilized as "directional tools" to develop rational projections based on realistic assumptions. For example, the current planning model suggests that major wars or regional conflicts will not transpire or impact demand for VA services. Will this assumption hold true? No one knows for sure. Furthermore, the model does not take into account potential consolidation efforts or changes in our current mission. There are many unknowns when models are completed and those organizations that develop these predictions do so based on reasonable assumptions and available information that they have available to them. VAPAHCS personnel must determine whether the model predictions are realistic and reasonable. Once the evaluation process has been completed, developing a strategic planning framework must then be formulated and implemented.

VAPAHCS' actual workload and future actuarial statistical predictions are charted below:



Source:

1. *VISTA reports FY97 – FY 01*
2. *Planning model projections -Integrated Planning Model v00, Planning Systems Support Group, Gainesville, FL*

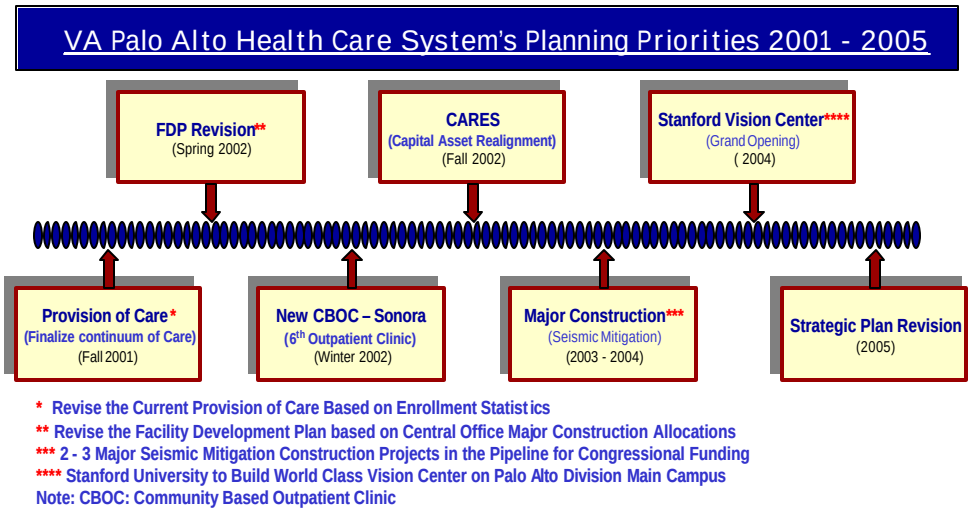
Strategic Planning Framework (cont'd)

- Section 2: Developing Planning Parameters

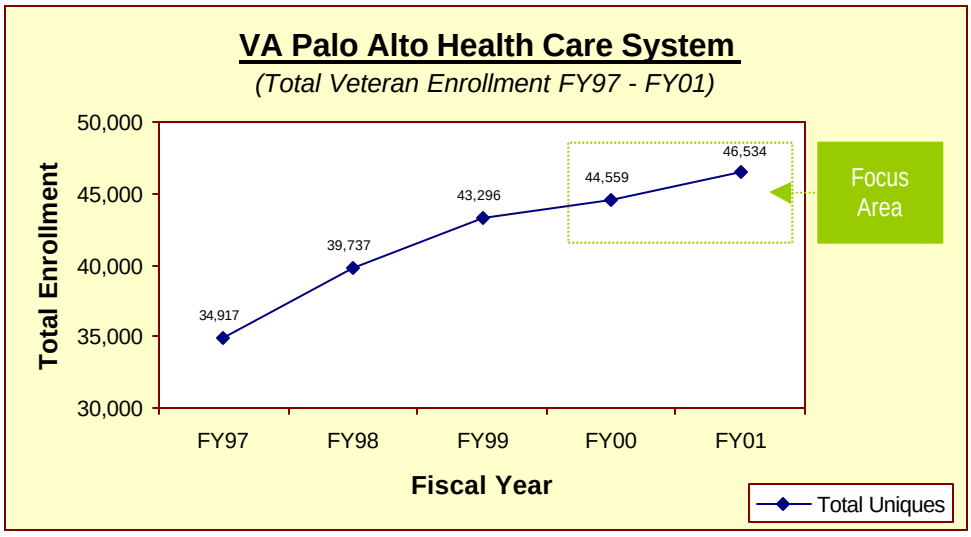
The VAPAHCS utilized several statistical "tool kits" to develop both short and long-term plans. In the following Strategic Plan, you will notice that the VAPAHCS has made significant efforts to transition from inpatient to outpatient medical care. Since 1994, the VAPAHCS opened six new Community Based Outpatient Clinics (CBOC) to ensure that we improve "access to care." Many of these decisions were based on planning model findings and patient satisfaction survey results.

As we plan for the future, we anticipate the need to realign clinical services at each of our facilities to ensure that we have the appropriate "provision of care." Limited financial resources mandate the need to be fiscally responsible to our stakeholders. Offering every specialty service at each outpatient clinic would not be prudent. As fiscal constraints become more prominent, we must determine the appropriate provision of care at each location.

The VAPAHCS understands the need to continue expanding into new markets where treatment is not currently offered to our veterans. We will think "out of the box" to ensure that top-notch medical care is available to all our veterans. The following timeline identifies our "next steps" that we will take to streamline our operations to ensure that we continuously improve the caliber of care that we provide our veterans.



VA Headquarters (VAHQ) will continue to make resource allocation decisions based on enrollment statistics. We are confident that our growth in total veteran enrollment will continue to increase. We are proud of our enrollment record - our total veteran enrollment has increased by approximately 30 percent since FY97.



Source:
Sierra Pacific Network total uniques

Health System Overview

- Section 3: VA Sierra Pacific Network (VISN 21) Overview

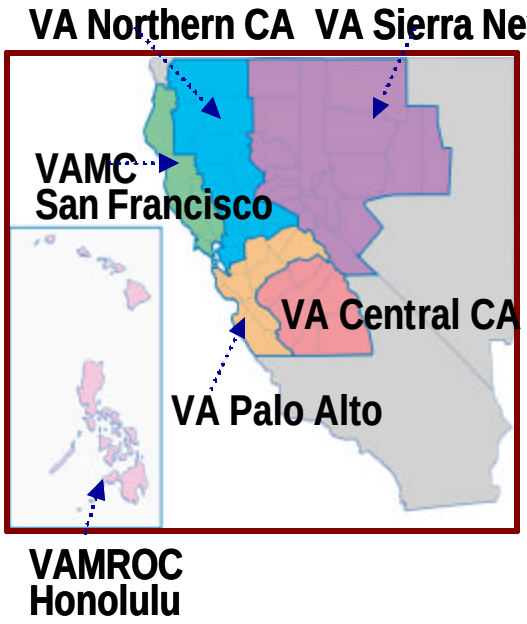
The VA Sierra Pacific Network is one of the 22 Veterans Integrated Service Networks (VISN) in the Veterans Healthcare Administration (VHA). The VA Sierra Pacific Network (VISN 21) serves 1.3 million veterans residing in 71 counties of northern and central California, northern Nevada, Hawaii, the Philippines, and several Pacific Islands. The VAHAHCS is the major tertiary referral center for VISN 21. The other VA health care systems within VISN 21 and their geographic boundaries are depicted in the chart below.

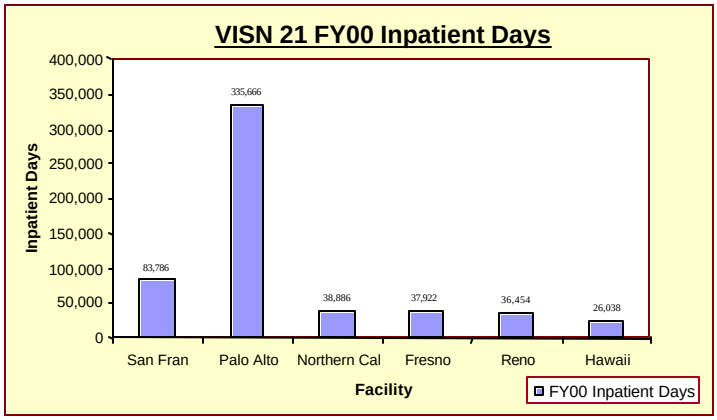
In fiscal year 2000, VISN 21 provided care to more than 168,000 veterans. Today, VISN 21 operates 816 hospital beds, 802 nursing home beds, and 100 domiciliary beds. Nearly 1.7 million outpatient visits are provided to veterans within our network each year. Access continues to be a significant issue for the Network. Substantial progress has been made in establishing new CBOCs and expanding services throughout the following six systems: VA Central CA Health Care System, VAMC San Francisco, VAMROC- Honolulu, VA Northern CA Health Care System, VA Palo Alto Health Care System, and VA Sierra Nevada Health Care System.

VA Sierra Pacific Network (VISN 21)

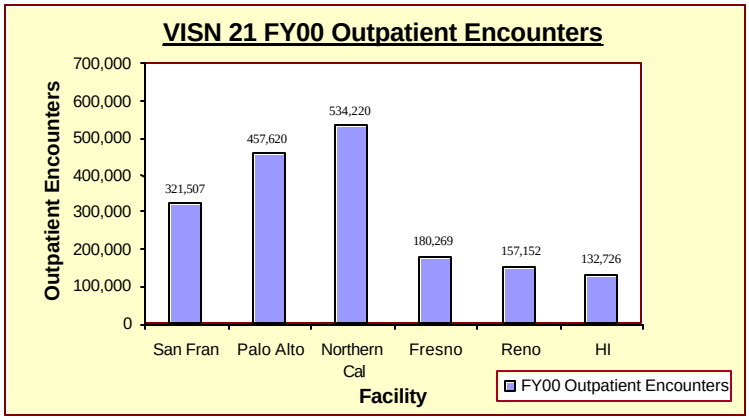
FACT SHEET

- VISN 21 is 1 of 22 VISNs nationwide
- Total of 6 health care systems in northern and central CA, Hawaii and the Philippines
- VA Palo Alto Health Care System provided 25% of all outpatient care in FY00
- VA Palo Alto Health Care System provided 60% of all inpatient days in FY00





Source:
1. KLF FY00 Workload Reports



Source:
1. KLF FY00 Workload Reports

VA Palo Alto Health Care System Overview

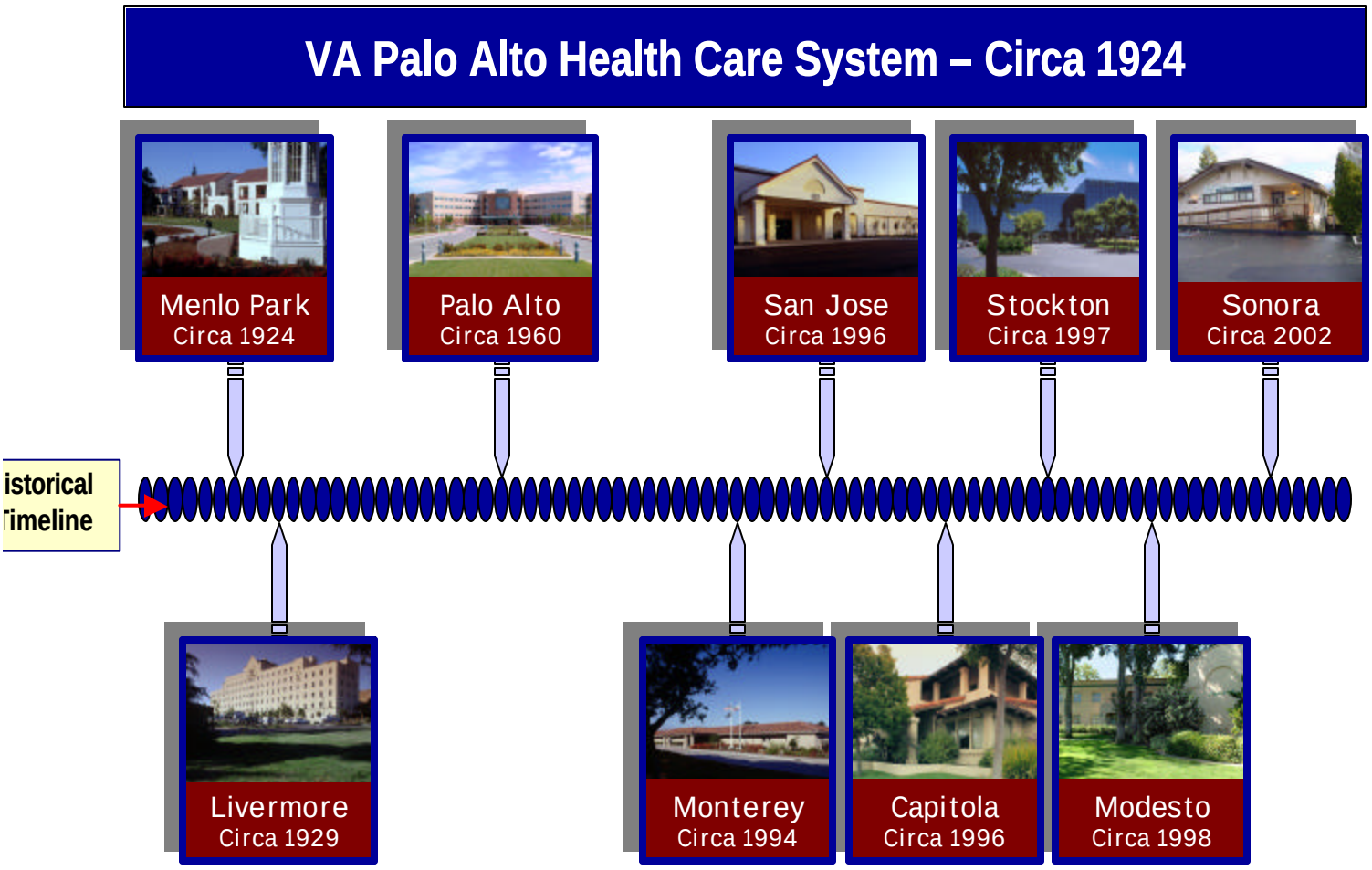
- Section 3: Historical Roots

The VAPAHCS began operations nearly 80 years ago. The US Army transferred the Fort Fremont property, in Menlo Park, to the Veterans Administration. The Fort Fremont transfer will forever be remembered as the beginning of what we know today as the Veterans Healthcare Administration (VHA). The US Army property transfer essentially established the very first US veteran's hospital in our nation's history.

Since 1924, the VAPAHCS has grown into one of the largest Veterans Health Care Systems in the United States. Much has changed since the Menlo Park Veteran's Hospital began operation in 1924. Since that time, the VAPAHCS has become a major tertiary care facility providing state-of-the-art medical care to hundreds of thousands of veterans.

In the last two decades, the VAPAHCS has integrated three veterans' hospitals into one system. These three hospitals, Menlo Park, Palo Alto, and Livermore, now play an integral role in the delivery of medical treatment to our veterans who live throughout our catchment areas. The VAPAHCS has been marked by both tragedy and triumph. We have survived devastating earthquakes and surmounted world conflicts. Throughout history, we have made tremendous strides to ensure that our veterans receive the very best medical care available.

Overtime, the VAPAHCS has transitioned from an inpatient care setting to providing ambulatory and preventative care in an outpatient clinics in their local communities. In the mid 1990s, our healthcare system established several new outpatient clinics within our ten country catchment area. Our goal has been simple; provide outpatient care in our veteran's home communities. To that end, we have added outpatient clinics in Monterey, San Jose, Capitola, Modesto, Stockton and soon an outpatient clinic will open in Sonora.



VA Palo Alto Health Care System Overview (cont'd)

- Section 3: Fact Sheet & Who We Are

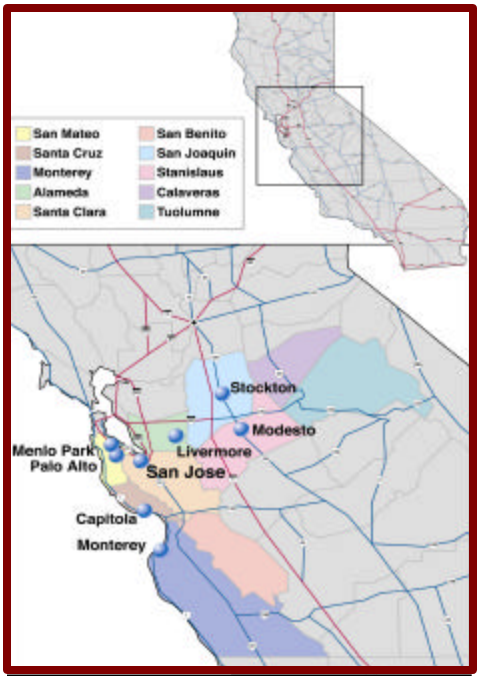
Since operations began in 1924, the VAPAHCS has grown into one of the largest VA health care systems in the Veterans Healthcare Administration (VHA) and the sixth largest in the State of California. Our integrated delivery system has focused its efforts on improving "access to care" – ensuring veterans receive top-notch medical treatment.

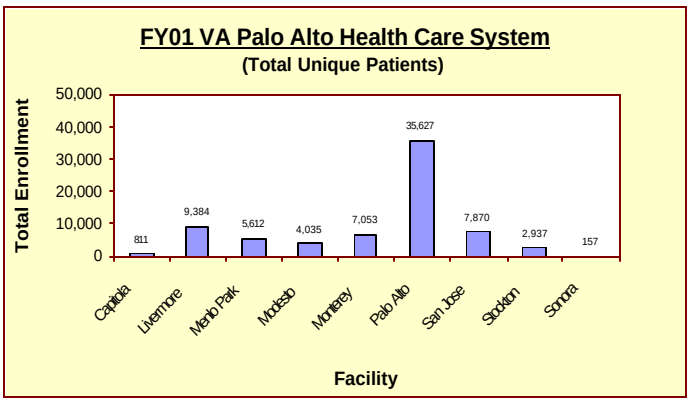
The VAPAHCS is a major tertiary referral center serving VISN 21. There are three inpatient divisions with the primary campus located in Palo Alto; the Menlo Park Division located seven miles to the north and the Livermore Division located 40 miles east of the Palo Alto Division.

VA Palo Alto Health Care System – Site Locations

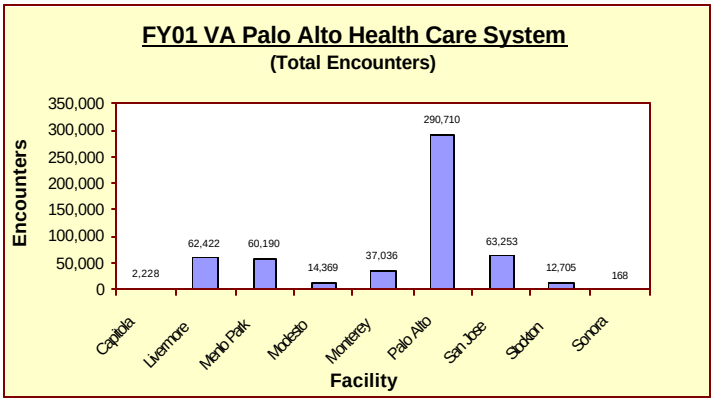
FACT SHEET

- VA Palo Alto Health Care System encompasses 10 counties in CA
- Catchment area ~13,500 sq miles
- Approximately 440,000 veterans live within this 10 county catchment area
- The VA Palo Alto Health Care System has successfully transitioned from inpatient to outpatient care
- We opened 6 new outpatient clinics since 1994 equating to 20,000 new patients





Source:
Austin Data Base (11 months ending Sep 01)



Source:
Austin Data Base (11 months ending Sep 01)

VA Palo Alto Health Care System Overview (cont'd)

- Section 3: Veteran Dispersion within a 10 County Cathment Area

Estimated 2000 Demographics:

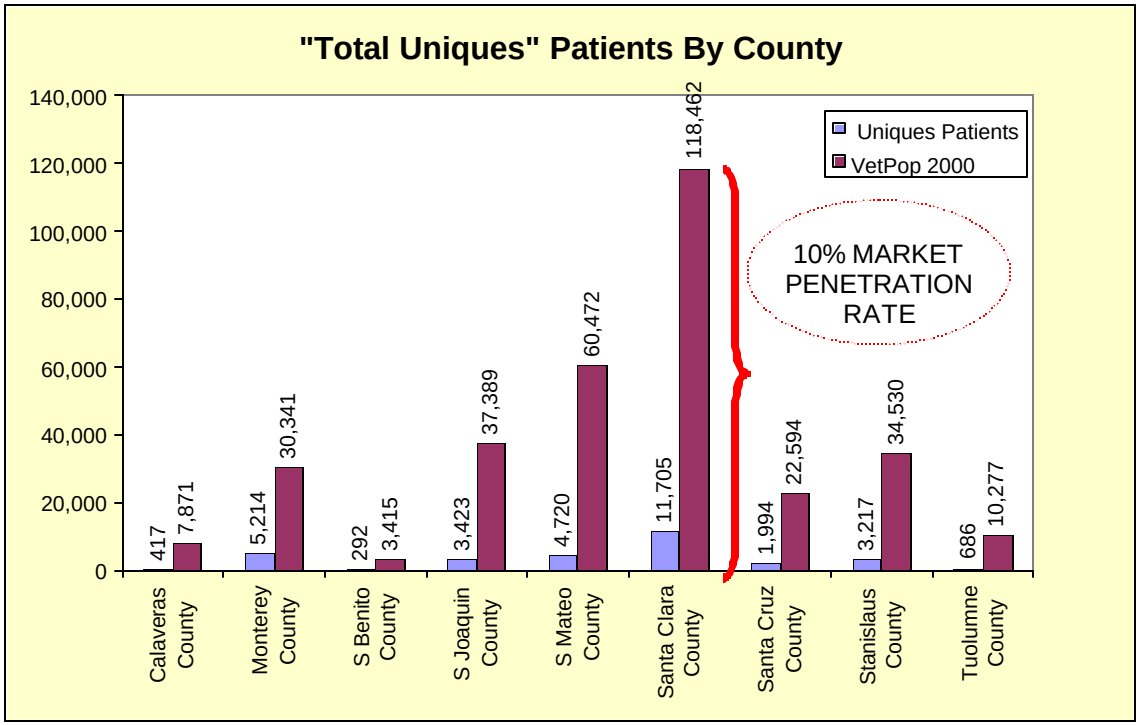
County	Veteran Population	County	Veteran Population
Alameda *	107,684	San Mateo *	60,472
Calaveras	7,871	Santa Clara	118,462
Monterey	30,341	Santa Cruz	22,594
San Benito	3,415	Stanislaus	34,530
San Joaquin	37,389	Tuolumne	10,277

** Alameda County is shared with the Northern California Health Care System and San Mateo County is shared with VA Medical Center, San Francisco*

The 2000 total veteran population for these 10 counties is estimated to be 433,035. Since our health care system is a tertiary referral center with a number of regional and national treatment programs, our true catchment area is actually significantly more expansive and diverse than the demographics of our Primary Service Area (PSA) would suggest. The veteran population has been increasing slightly over the past few years, but projections indicate declining populations in future years.

Much of the veteran population is concentrated in the major urban centers located principally in the San Francisco Bay Area Peninsula. There is an increasing trend for the veteran population to be migrating from our large metropolitan centers to more rural communities, particularly in the Sacramento Valley and the foothills of the Sierra Nevada mountain range.

VA Palo Alto Health Care System Market Penetration Rates:



Source:

1. *KLF Menu data source run date 5/29/2001projection*
2. *Population estimates based 1990 US census reports*

VA Palo Alto Health Care System Overview (cont'd)

- Section 3: Fact Sheet

The VAPAHCS employs approximately 2,880 FTEE and operates a total of 913 beds including a 100 bed Domiciliary, a 125-bed geropsychiatric nursing home and 245 skilled nursing home care beds at Menlo Park and Livermore. Approximately 384,000 outpatient visits were recorded in FY 2000. The VAPAHCS supports a number of special regional referral and treatment centers, including:

- Spinal Cord Injury Center
- Western Blind Rehabilitation Center
- National Center for PTSD

Other major referral programs offered include Cardiac Surgery and Homeless Veterans Rehabilitation. We successfully competed for an award for one of only five Mental Illness Research & Education Clinical Centers (MIRECC) in the VA. We have one of the initially funded GRECC's with a new focus on aging and mobility. One of only two initial Patient Safety Centers of Inquiry was sited at the Palo Alto Division, as was the first Center for Quality Management in HIV Care. Further, the facility's HIV treatment program and Homeless Domiciliary have been officially designated as "centers of excellence" by VA Headquarters. The VAPAHCS enjoys a strong affiliation with the Stanford University School of Medicine. It hosts extensive research centers in Alzheimer's Disease, spinal cord regeneration, robotic aids for quadriplegics, digestive diseases, simulation for healthcare training, and health economics. The VAPAHCS serves as an authorized provider for our TRICARE Region, and is a Special Treatment Service (STS) provider in cardiac surgery for active duty military.

The VAPAHCS catchment area has been the site of a significant number of military base closures in the past five years. Our organization has been designated as a "provider" for those TRICARE beneficiaries who have lost access to military treatment facilities. Non-veterans may also be cared for under sharing agreements between the VA and other healthcare agencies. VAPAHCS also provides humanitarian aid to non-veterans on an emergency basis.

The average income of veterans in our catchment area is significantly higher than the nationwide average. Accordingly, the market share of patients treated by our health care system is also less than the national average. Another significant characteristic of our market is the proportion of health care services that are delivered to California residents by Health Maintenance Organizations (HMO's), very effective competitors for the health care dollars of veterans residing in our catchment area.

The average age of our veteran patients is 57 years and increasing; 93% of our patients are male and the majority of them travel less than 15 miles for primary care services. The following table, from the VA Planning Systems Support Group, estimates the total veteran population for VAPAHCS will decline from 361,444 to 327,230 between 2000 and 2005.

VA Palo Alto Health Care System Overview (cont'd)

- Section 3: Integrated Delivery System: Provision of Care

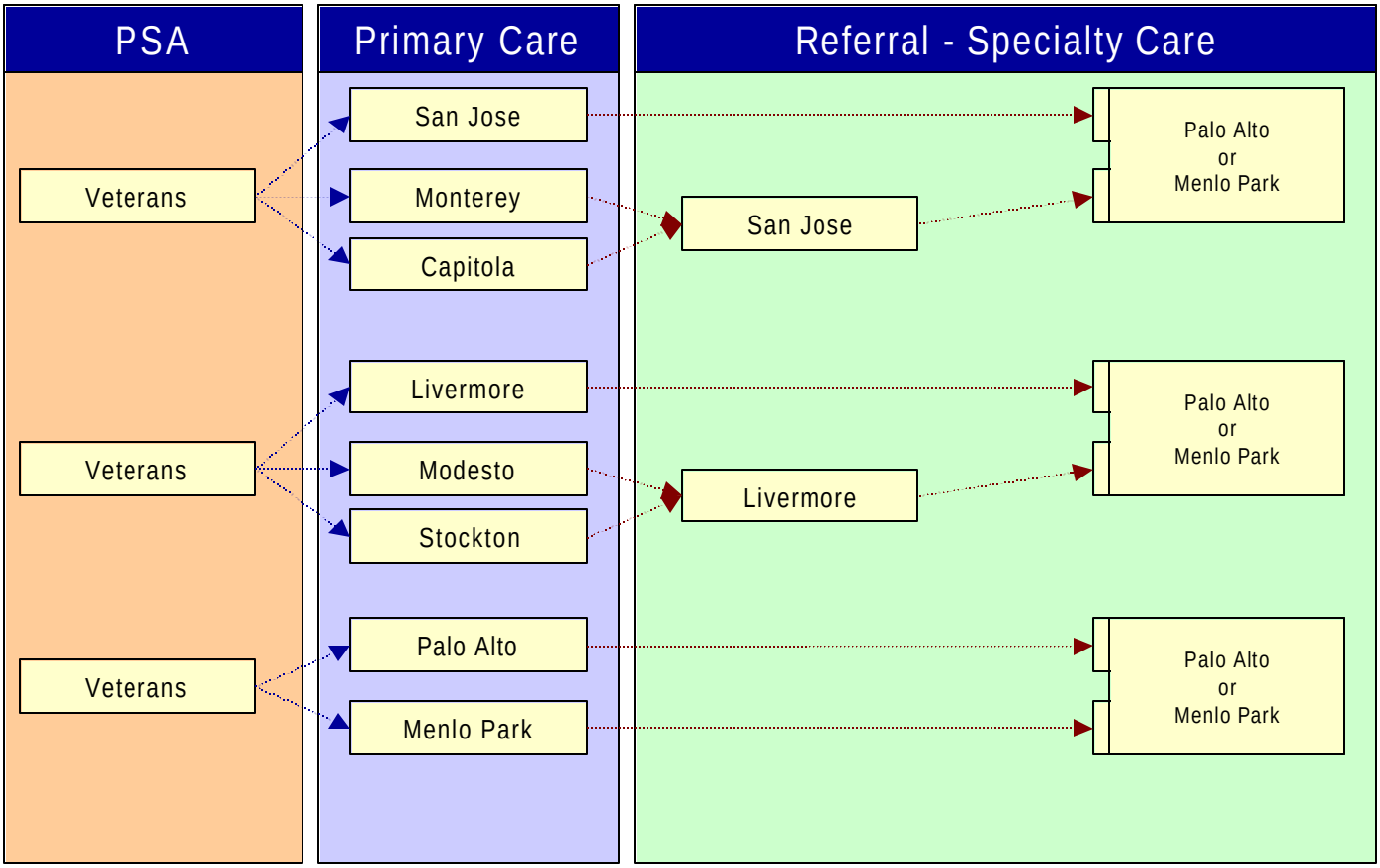
Clinical services within VAPAHCS are arranged in a hub and spoke model with increasing levels of care and complexity being available as one moves closer to the Palo Alto hub. Services at CBOCs are also arranged in a hub and spoke fashion. The CBOCs at Monterey and Capitola refer patients to San Jose while Modesto and Stockton CBOCs refer patients to Livermore for the increased level of services available at these two locations. This arrangement allows veterans to get the bulk of their care close to their home and allows them to avoid travel to Palo Alto except for inpatient admissions, some medical and surgical subspecialties, and surgical and complex radiological procedures.

The arrangement of services at each site has been provided largely on a historical basis. Over the next 12-18 months, the aim will be to realign the services at each site in such a way as to provide the optimum balance between patient access and clinical efficiency. The services provided at each site will be done in such a fashion to support the provision of primary care and mental health services. This process will refine the hub and spoke model so that primary care, mental health services and allied fields supporting these services are available close to each veteran's community. Increased access to medical and surgical subspecialties, inpatient services and complex radiologic imaging will occur as one moves closer to the Palo Alto Division.

CBOC Provision of Care

- Primary Care
- Mental Health
- Optometry
- Plain Radiology
- Urology
- Dermatology
- Podiatry
- GI
- Cardiology

Primary care and mental health services are currently available at each CBOC. Other basic services that should be provided within a CBOC or within the hub and spoke system of CBOC should consist of:



VA Palo Alto Health Care System Overview (cont'd)

- Section 3: VA Palo Alto Health Care System Outpatient Clinical Inventory

Clinical Inventory - Outpatient	Palo Alto	Menlo Park	Livermore	San Jose	Monterey	Capitola	Stockton	Modesto	Sonora
Allergy and Immunology Clinic	X								
Andrology Clinic	X								
Audiology Clinic	X	X	X	X	X				
Blind Rehabilitation Clinic	X								
Brain Injury Rehabilitation Clinic	X								
Cardiology Clinic	X		X	X	X				
Cardiothoracic Surgery Clinic	X								
Chaplain Service	X	X	X	X					
Compensated Work Therapy		X							
Coumadin Clinic	X		X						
Day Treatment		X							
Dental Clinic	X	X	X	X					
Dermatology Clinic	X	X	X	X	X				
Diabetes Clinic	X	X	X	X					
Dietetic / Nutrition Clinic	X	X	X	X	X				
Domiciliary After Care		X							
Ears, Nose, and Throat (ENT)	X		X	X					
Employee Health	X	X	X						
Endocrinology Clinic	X								
Gastroenterology (GI) Clinic	X		X	X	X				
General Internal Medicine Clinic	X	X	X	X	X	X	X	X	X
General Surgery Clinic	X		X	X	X				
Geriatric Clinic	X	X	X	X					
GRECC	X								
Hand Surgery Clinic	X		X						
Hematology Clinic	X		X						
Home-Based Primary Care	X			X					
Immune Clinic	X		X	X	X				
Infectious Disease Clinic	X								
Nephrology Clinic	X		X						
Neurology Clinic	X		X	X	X				
Neurosurgery Clinic	X		X						
Nuclear Medicine Clinic	X								
Mental Health Clinic	X	X	X	X	X	X	X	X	X
Occupational Therapy Clinic	X	X	X	X	X				
Oncology Clinic	X		X						
Ophthamology Clinic	X		X						
Optometry Clinic	X	X	X	X	X				
Orthopedics Clinic	X		X	X	X				
Pathology and Lab Services	X	X	X	X	X				
Pharmacy / Clinical Pharmacy	X	X	X	X	X				
Physical Therapy / PM&R Clinic	X	X	X	X	X				
Plastic Surgery Clinic	X		X						
Podiatry Clinic	X	X	X	X	X				
Prosthetics / Orthotics Clinic	X			X					
PTSD Programs		X		X	X	X		X	
Pulmonary Medicine Clinic	X		X	X	X				
Radiation Therapy Clinic	X								
Radiology Services	X	X	X	X	X				
Recreation Therapy Clinic	X	X							
Respite Programs				X					
Rheumatology Clinic	X		X	X	X				
Smoking Cessation Clinic	X	X	X	X	X	X	X	X	X
Sleep Disorder Clinic	X								
Social Work Services	X	X	X	X	X	X	X	X	X
Spinal Cord Injury Clinic	X								
Substance Abuse Clinic	X	X	X	X	X	X	X	X	X
Urology Clinic	X	X	X	X	X				
Vascular Surgery Clinic	X		X						
Vocational Rehabilitation Clinic		X							
Wellness Services	X	X	X	X	X	X	X	X	X
Women's Health Clinic	X	X	X	X	X				

Note:
Sonora Outpatient Clinic to open in FY02

VA Palo Alto Health Care System Overview (cont'd)

- Section 3: Division Overview

Consolidation of VA Medical Centers (VAMCs):

The VAPAHCS has become an integrated delivery system encompassing 3 main divisions: Palo Alto, Menlo Park and Livermore. These three divisions along with six Community Based Outpatient Clinics (CBOCs) are integral in the delivery of primary and specialty care to veterans in our catchment area. VAPAHCS serves as a tertiary care referral center for VISN 21 and the Western United States.

The Palo Alto Division is the site of all tertiary care, and the site of all acute inpatient care in psychiatry, medicine, and surgery. The Palo Alto campus is also home to VA special programs in Blind Rehabilitation and Spinal Cord. Several miles away, the Menlo Park Division is home to nursing home units, geropsychiatry and VA special programs in PTSD, Homelessness and treatment of Chronic Mental Illness. The Livermore Division is home to a wide range of outpatient clinics offering a wide array of outpatient services. A 120-nursing home unit is also situated on the Livermore campus.

Palo Alto

- Main VA Palo Alto Health Care System Division
- Primary referral center for med/ surg patients
- Acute Psych – 72 beds
- Internal Medicine –49 beds
- Intermediate Medicine – 63 beds
- Spinal Cord Injury – 43 beds
- Surgical – 42 beds
- Rehab Medicine - 16 beds
- Western Blind Center – 32 beds

Menlo Park

- Main Division specializing in Mental Health
- Primary referral center for Domiciliary services
- Primary referral center for PTSD services
- Gero psych – 125 beds
- Long Term Care – 150 beds
- Domiciliary – 100 beds
- PTSD – 50 beds
- PRRTP Beds – 62 beds

Livermore

- Division serving VA Patients in Alameda and surrounding counties
- Subacute – 10 beds
- Long Term Care – 120 beds

VA Palo Alto Health Care System Overview (cont'd)

- Section 3: Community Based Outpatient Clinics (CBOC)

In addition to inpatient services at Palo Alto, Menlo Park, and Livermore, ambulatory care services are provided at community based outpatient clinics in San Jose, Monterey, Modesto, Stockton and Capitola.

New clinics in veterans' communities has led to an continued growth in enrollment. We have made significant effort to transfer personnel and resources into these new venues. Our efforts have been highly successful. Our growth in veteran enrollment can be attributed to new outpatient clinics coupled with outreach efforts to educate veterans about the services that we provide.

In FY02, the Modesto Clinic will move into its new home as seen in the picture depicted below. In addition, we will open our sixth outpatient clinic to accommodate and treat those veterans in San Joaquin County. The location of this new outpatient clinic will be in the City of Sonora.

VA Palo Alto – Integrated Delivery System

Palo Alto

Enrollment: 34,869 (FY00)
Encounters: 378,982 (FY00)
Employees: 1,763 FTE (FY01) *

Menlo Park

Enrollment: 5,643 (FY00)
Encounters: 60,548 (FY00)
Employees: 607 FTE (FY01) *

Livermore

Enrollment: 8,502 (FY00)
Encounters: 63,395 (FY00)
Employees: 317 FTE (FY01) *

San Jose

Enrollment:: 6,900 (FY00)
Encounters: 67,409 (FY00)
Employees: 78 FTE (FY01) *

Stockton

Enrollment:: 2,484
Encounters: 11,090
Employees: 15 FTE (FY01) *

Monterey

Enrollment:: 6,275
Encounters: 34,647
Employees: 45 FTE (FY01) *

Modesto

Enrollment: 2,843
Encounters: 12,499
Employees: 12 FTE (FY01) *

Capitola

Enrollment:: 534
Encounters: 1,677
Employees: 3 FTE (FY01) *

* *On Board – non-cum as of PP01-17 ~2,845*

VA Palo Alto Health Care System Overview (cont'd)

- Section 3: Palo Alto Division

The Palo Alto Division (PAD) of the VAPAHCS began operations in 1960 as the "planned" Menlo Park replacement facility. Due to a dramatic growth in the San Francisco Bay Area veteran population, the consolidation of VA services to the PAD campus never came to fruition. The VA kept operations open at both locations and continues to maintain capacity at both Menlo Park and Palo Alto campuses.

On October 17, 1989, the Loma Prieta Earthquake left the main VA Palo Alto hospital building in utter disrepair. Soon after this unfortunate tragedy, the VA condemned the main hospital, Building 1, which would eventually lead to the razing of that facility because it was unsafe to keep open. In 1997, nearly a decade after that horrific event, the VAPAHCS opened a state-of-the-art replacement complex near the former site of Building 1. Today, this new complex, Building 100 and 101, stand as a landmark of America's will to rebuild and serve our nation's veterans. This complex is one of the most sophisticated medical treatment tertiary care centers in the Veterans Healthcare Administration (VHA). The VAPAHCS relies on these two new buildings for the provision of medical and surgical treatment for San Francisco Bay Area veterans.

Palo Alto Division

Enrollment: 34,869 (FY00)

Encounters: 378,982 (FY00)

Employees: 1,789 (FY01)

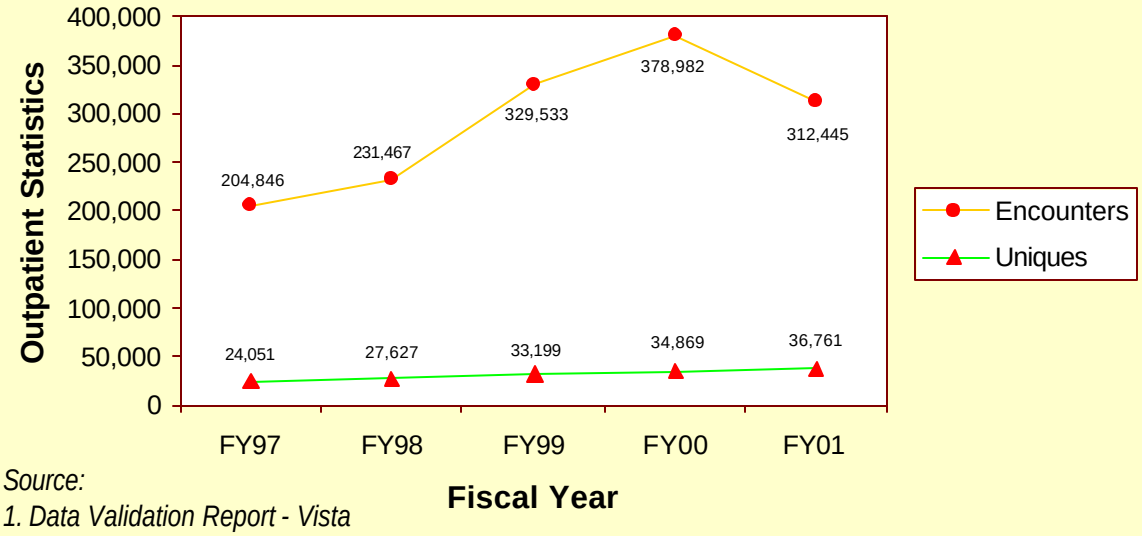
VA PAHCS
Veterans Affairs Palo Alto Health Care System

Provision of Care – Outpatient Services

- Allergy and Immunology
- Andrology
- Audiology
- Blind Rehabilitation
- Brain Injury Rehabilitation
- Cardiology
- Cardiothoracic
- Chaplain Services
- Coumadin
- Dental
- Dermatology
- Diabetes
- Dietetic
- ENT
- Employee Health
- Endocrinology
- Gastroenterology
- General Internal Medicine
- General Surgery
- Geriatrics
- GRECC
- Hand Surgery
- Home-Based Primary Care
- Immune
- Infectious Disease
- Nephrology
- Neurology
- Neurosurgery
- Mental Health
- Occupational Therapy
- Oncology
- Ophthamology
- Optometry
- Orthopedics
- Pathology and Lab Services
- Pharmacy Services
- Pharmacy – Clinical
- Physical Therapy/PM&R
- Plastic Surgery
- Podiatry
- Prosthetics/Orthotics
- Pulmonary Medicine
- Radiation Therapy
- Radiology Services
- Recreation Therapy
- Rheumatology
- Smoking Cessation
- Sleep Disorders
- Social Work Services
- Spinal Cord Injury
- Substance Abuse
- Urology
- Vascular
- Wellness
- Women's Health

Palo Alto Division Outpatient Workload

FY97 - FY01



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VA Palo Alto Health Care System Overview (cont'd)

- Section 3: Menlo Park Division

The Menlo Park Division (MPD) of the VAPAHCS began operations in 1924 when the US Army transferred the Menlo Park property to what is now known as the Veterans Healthcare Administration (VHA). Throughout the past 80 years, the Menlo Park Division has played an important role ensuring that San Francisco Bay Area veterans receive first class medical treatment.

Today, the Menlo Park facility has been transformed into one of three divisions of the VAPAHCS. Nursing home units, at the Menlo Park campus, ensure that our aging veterans receive top notched medical care within the Division's long-term care facilities. In the mid-90s, the VAPAHCS constructed a new 100 bed domiciliary on the Menlo Park campus. In addition to the domiciliary, the majority of inpatient and outpatient mental health programs have been consolidated within the Menlo Park Division. Post Traumatic Stress Disorder (PTSD), substance abuse and addiction treatment programs are also located on the grounds of the Menlo Park campus.

In addition to providing geriatric and mental health inpatient programs on the Menlo Park campus, the Nutrition and Food Service is responsible for preparing all inpatient meals for the VAPAHCS. This daily task is no easy feat. Each day, the Menlo Park Nutrition and Food Service facility prepares, transports, and distributes nearly 2,500 meals to all three divisions. This food production operation equates to approximately 900,000 meals annually. The Menlo Park Division's central location to the interstate makes the campus ideal for the delivery of meals to inpatient facilities located at Palo Alto, Menlo Park, and Livermore.

In summary, the Menlo Park Division will continue to play a vital role in the delivery of medical care to our nation's veterans. The VAPAHCS will ensure that the resources, both financial and personnel/clinical, are available such that we can provide superior medial care for our growing veteran population. To that end, the VAPAHCS will ensure that long-term geriatric care and a continuum of mental health programs continue to remain viable and accessible to our veteran population.

Menlo Park Division

Enrollment: 5,643 (FY00)

Encounters: 60,548 (FY00)

Employees: 601 (FY01)

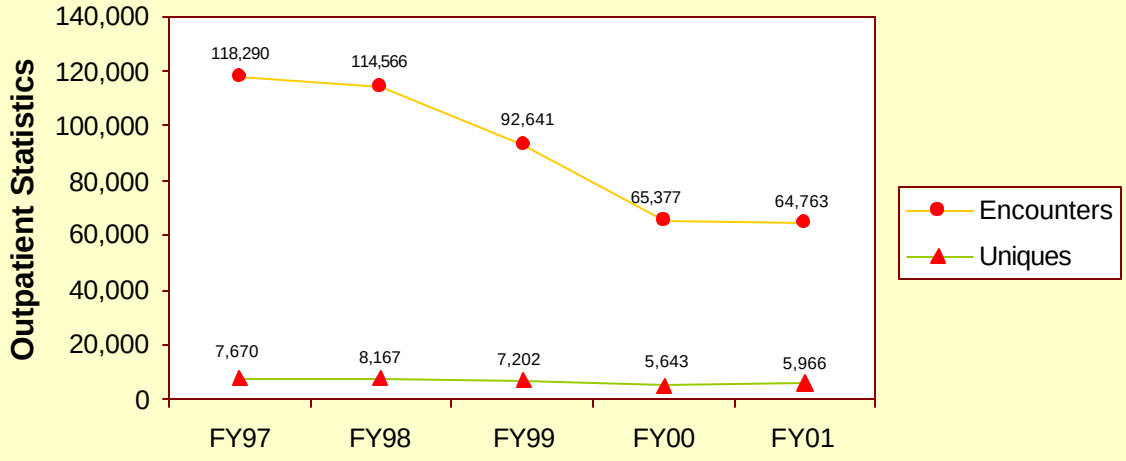
VA PAHCS
Veterans Affairs Palo Alto Health Care System

Provision of Care – Outpatient and Clinical Services

- Audiology
- Chaplain Services
- Compensated Work Therapy
- Day Treatment
- Dental
- Dermatology
- Diabetes
- Dietetic
- Domiciliary After Care
- Employee Health
- General Internal Medicine
- Geriatrics
- Mental Health
- Occupational Therapy
- Optometry
- Pathology and Lab Services
- Pharmacy Services
- Physical Therapy/PM&R
- Podiatry
- PTSD Programs
- Radiology Services
- Recreation Therapy
- Smoking Cessation
- Social Work Services
- Substance Abuse
- Urology
- Vocational Rehabilitation
- Wellness
- Women's Health

Menlo Park Division - Outpatient Workload

FY97 - FY01



Source:
1. Data Validation Report - Vista

VA Palo Alto Health Care System Overview (cont'd)

- Section 3: Livermore Division

The Livermore Division (LVD) of the VAPAHCS began operations in 1929 at a tuberculosis hospital. Building 62, the main hospital building, was constructed in the late 1940s and a nursing home unit was opened on the Livermore grounds in 1980. The Livermore VAMC operated as an independent medical center until the mid-1990s.

In 1995, the VAMC - Livermore was incorporated into the VAPAHCS. Today, the Livermore Division plays an integral role in the provision of medical care to our veteran population located in the Alameda, Calaveras, San Joaquin, and Tuolumne counties.
The addition of Stockton, Modesto, and Sonora outpatient clinics has increased Livermore Division's enrollment and volume of subspecialty referrals.

As many Bay Area residents migrate north, the VAPAHCS anticipates continued growth within the Livermore Division's catchment area. The Livermore campus offers a broad range of subspecialty clinics to accommodate the veteran population who reside in these various communities. Without the Livermore campus, veterans would be forced to commute over an hour to the Palo Alto campus. In our pursuit to improve access to medical care, the Livermore Division will continue to play an essential role in the VAPAHCS' provision of care.

In summary, the continued growth of VAPAHCS outpatient clinics in Stockton, Modesto, and Sonora signal the need to maintain the Livermore Division as an integral part of our patient care delivery system. Livermore's primary care, subspecialty clinics, sub-acute inpatient unit and nursing home facility are effective components of the VAPAHCS.

Livermore Division

Enrollment: 8,502 (FY00)

Encounters: 63,395 (FY00)

Employees: 313 (FY01)

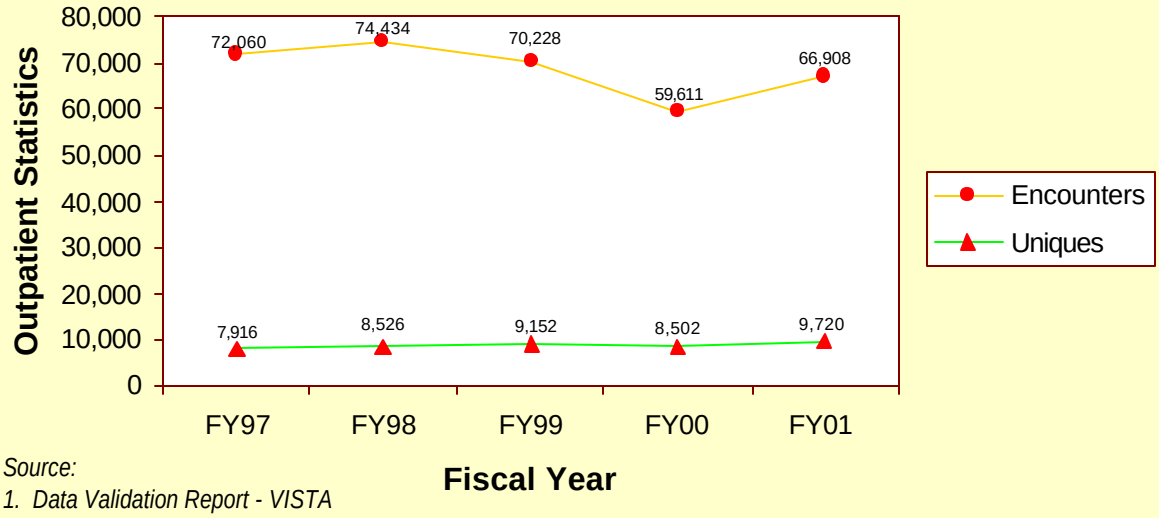
VA PAHCS
Veterans Affairs Palo Alto Health Care System

Provision of Care – Outpatient and Clinical Services

- Audiology
- Cardiology
- Chaplain Services
- Coumadin
- Dental
- Dermatology
- Diabetes
- Dietetic
- Ears, Nose, Throat (ENT)
- Employee Health
- Gastroenterology (GI)
- General Internal Medicine
- General Surgery
- Geriatrics
- Hand Surgery
- Hematology
- Immune Clinic
- Nephrology
- Neurology
- Neurosurgery
- Mental Health
- Occupational Therapy
- Oncology
- Ophthamology
- Optometry
- Orthopedics
- Pathology and Lab Services
- Pharmacy Services
- Physical Therapy/PM&R
- Plastic Surgery
- Podiatry
- Pulmonary Medicine
- Radiology Services
- Rheumatology
- Smoking Cessation
- Social Work Services
- Substance Abuse
- Urology
- Vascular Surgery
- Wellness
- Women's Health

Livermore Division - Outpatient Workload

FY97 - FY01



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VA Palo Alto Health Care System Overview (cont'd)

- Section 3: San Jose Outpatient Clinic

The VA San Jose Outpatient Clinic was established in 1996 to serve our large patient population located within the San Jose community. Today, the San Jose Clinic is the largest Community Based Outpatient Clinic (CBOC) in the VAPAHCS. Our total veteran population continues to increase as we, as an organization, improve our outreach efforts to inform veterans of the services that we offer. The magnitude of clinical services at this facility is enormous. The provision of care, in many ways, replicates that of the main Palo Alto Division. Our San Jose goal is to foster increased veteran enrollment and ensure that veterans receive the appropriate level of care that they deserve.

San Jose Clinic

Enrollment:: 6,900 (FY00)

Encounters: 67,409 (FY00)

Employees: 78 FTEE (FY01)

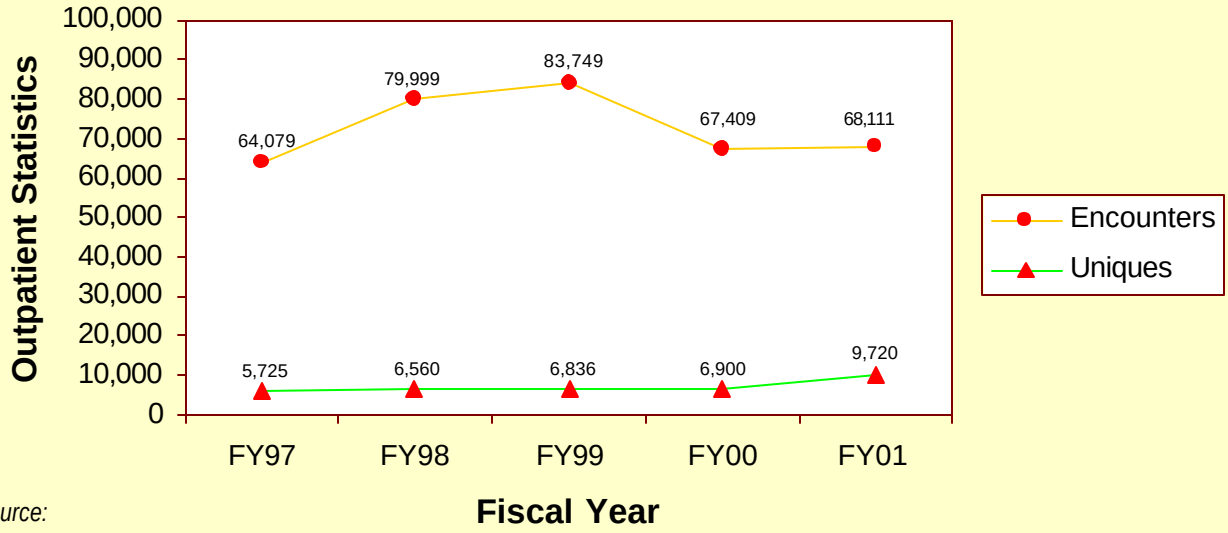
VA PAHCS
Veterans Affairs Palo Alto Health Care System

Provision of Care – Outpatient and Clinical Services

- Audiology
- Cardiology
- Chaplain Services
- Dental
- Dermatology
- Diabetes
- Dietetic
- Ears, Nose, Throat (ENT)
- Gastroenterology (GI)
- General Internal Medicine
- General Surgery
- Geriatrics
- Hand Surgery
- Hematology
- Home Based Primary Care
- Immune Clinic
- Nephrology
- Neurology
- Mental Health
- Occupational Therapy
- Optometry
- Orthopedics
- Pathology and Lab Services
- Pharmacy Services
- Physical Therapy/PM&R
- Podiatry
- Prosthetics
- PTSD
- Pulmonary Medicine
- Radiology Services
- Respite Programs
- Rheumatology
- Smoking Cessation
- Social Work Services
- Substance Abuse
- Urology
- Wellness
- Women's Health

San Jose Clinic - Outpatient Workload

FY97 - FY01



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1. Data Validation Report - VISTA

VA Palo Alto Health Care System Overview (cont'd)

- Section 3: Monterey Outpatient Clinic

The VA Monterey Outpatient Clinic was established in 1994 after the Base Closure and Realignment Commission (BRAC) decided to discontinue operations at Fort Ord. The large military retiree population made a VA Clinic in Monterey, CA an ideal location. The continued growth of veterans to this clinic and the potential growth in TRICARE workload is great news to this outpatient clinic. We anticipate continued growth and we are prepared to make significant capital improvements to this facility over the next several years. Installing a new roof, improving heating and ventilation (HV) and expanding clinics and services will take place between FY02 – FY04. Based on internal growth projections, we anticipate that the Monterey Clinic will surpass our San Jose Clinic in terms of total veteran enrollment by the end of fiscal year 2002.

Monterey Clinic

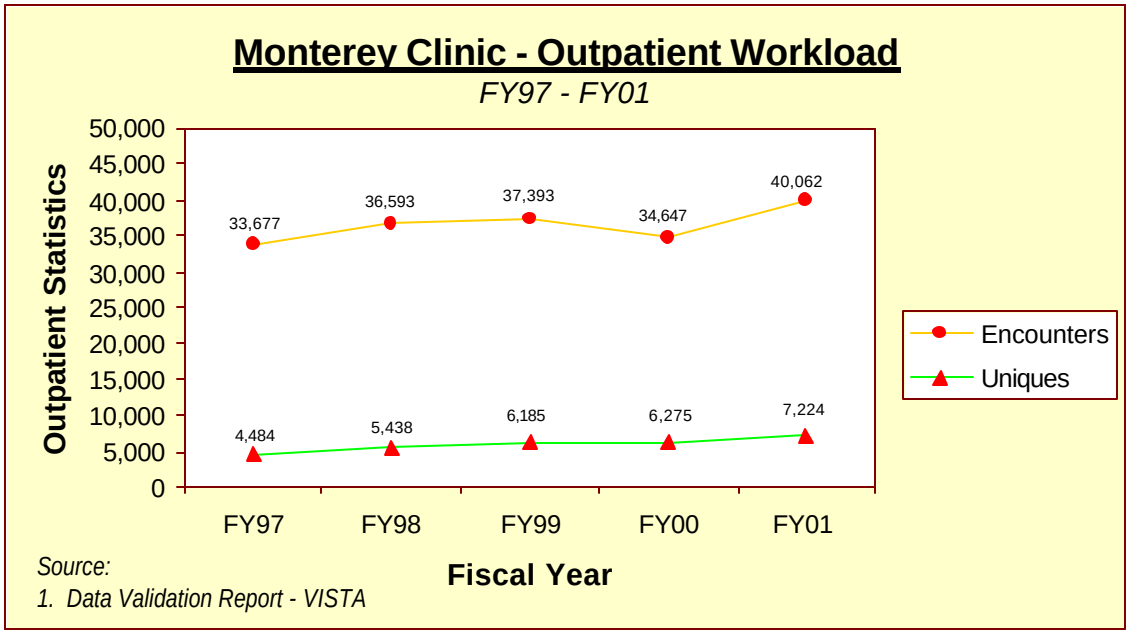
Enrollment: 6,275 (FY00)

Encounters: 34,647 (FY00)

Employees: 45 FTEE (FY01)

Provision of Care and Outpatient Services

- Audiology and Speech
- Cardiology
- Dermatology
- Gastroenterology
- General Internal Med
- General Surgery
- Neurology
- Mental Health
- Optometry
- Orthopedics
- Path and Lab Services
- Pharmacy Services
- PM&R
- Pulmonary Medicine
- Rheumatology
- Smoking Cessation
- Social Work Services
- Vascular



VA Palo Alto Health Care System Overview (cont'd)

- Section 3: Stockton Outpatient Clinic

The VA Stockton Outpatient Clinic was open in September 1997 on the grounds of the San Joaquin General Hospital. The VA Stockton Clinic, located in San Joaquin County, has enrolled approximately 3,000 veterans as of September 2001. According to Vet Pop 2000 actuarial statistics, approximately 37,000 veterans live in San Joaquin County. The Stockton Clinic is one of the VAPAHCS fastest growing outpatient clinics and this facility provides primary care services to veterans in the northern most portion of our catchment area.

Today, the VA Stockton Clinic offers primary care/general internal medicine and a broad range of mental health clinics. This clinic has grown from a small five-employee station to a clinic of fifteen. In FY01, the Stockton Clinic moved from the main San Joaquin Hospital Building to a separate medical building on the San Joaquin County Campus. As the Stockton Clinic continues to grow and evolve, the VAPAHCS will evaluate whether the clinic will need to be expanded to service our growing veteran population.

Stockton Clinic

Enrollment:: 2,484 (FY00)

Encounters: 11,090 (FY00)

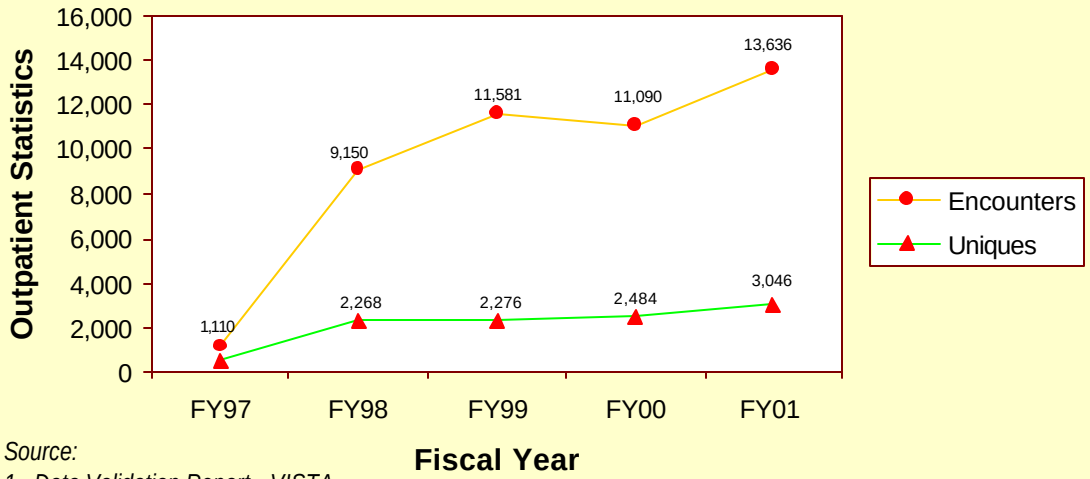
Employees: 15 FTEE (FY01)

Provision of Care and Clinical Services

- General Internal Medicine
- Mental Health
- Smoking Cessation
- Social Work Service

Stockton Clinic - Outpatient Workload

FY97 - FY01



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VA Palo Alto Health Care System Overview (cont'd)

- Section 3: Modesto Outpatient Clinic

The VA Modesto Outpatient Clinic was established in 1998 in temporary trailers. The VA Modesto Clinic, located in Stanislaus County, has enrolled approximately 4,000 veterans as of September 2001. According to VetPop 2000 actuarial statistics, approximately 34,500 veterans live in Stanislaus County. The Modesto Clinic is by far the fastest growing outpatient clinic in the VAPAHCS in terms of real percentage growth in the total number of new veterans to this clinic.

In November 2001, the VA Modesto Outpatient Clinic will move into its new home as depicted in the picture below. The "Glass Building" as it is referred to by Modesto residents, is a well-known local landmark and will be a promising asset as we entice local veterans to enroll into the VAPAHCS. In the next six months, we will determine whether any additional clinics and staff are needed once the clinic is fully operational.

Modesto Clinic

Enrollment: 2,843 (FY00)

Encounters: 12,499 (FY00)

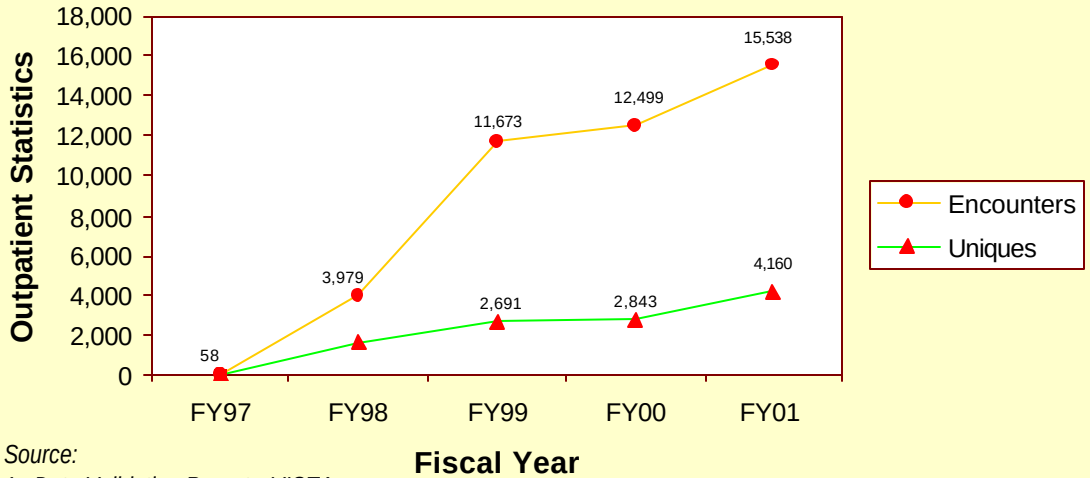
Employees: 12 FTEE (FY01)

Provision of Care and Clinical Services

- General Internal Medicine
- Mental Health Services
- Smoking Cessation
- Social Work Service

Modesto Clinic - Outpatient Workload

FY97 - FY01



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VA Palo Alto Health Care System Overview (cont'd)

- Section 3: Capitola Outpatient Clinic

The VA Capitola Outpatient Clinic was open in 1996. The, clinic's location is situated between VA facilities in San Jose and Monterey. The VA Capitola Clinic, located in Santa Cruz County, has enrolled over 800 veterans as of September 2001. According to Vet Pop 2000 actuarial statistics, approximately 22,500 veterans live in Santa Cruz County.

The VA Capitola Clinic offers primary care/general internal medicine and a broad array of mental health clinics. The total veteran enrollment is expected to double since last fiscal year. The VAPAHCS will continue to aggressively market our services within the local community. Capitola patients who require specialized services have the option of receiving additional medical treatment in Monterey, Palo Alto or San Jose.

Capitola Clinic

Enrollment: 534 (FY00)

Encounters: 1,677 (FY00)

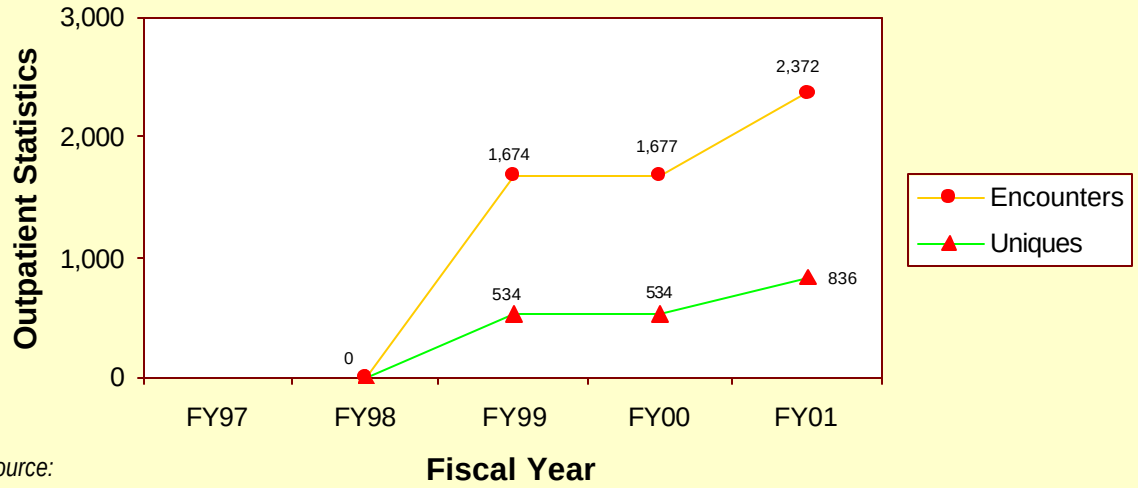
Employees: 3 FTEE (FY01)

Provision of Care and Clinical Services

- General Internal Medicine
- Mental Health
- Smoking Cessation
- Social Work Service

Capitola Clinic - Outpatient Workload

FY97 - FY01



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1. Data Validation Report - VISTA

Patient and Employee Assessment

- Section 4

Patient Assessment

Patient assessment takes many forms, from individual assessments of prevention and treatment needs, to general assessment of expectations of health care services provided. We as a health care system collect and use assessment data in many ways. Customer Satisfaction Surveys are performed on a national level and compared to community standards. Similar, surveys are administered locally by volunteers to enable us to obtain information about the performance of specific clinics or inpatient care areas. This data is then distributed to and discussed with the services providing direct patient care and to those providing other services that contribute to the success of the system.

VAPAHCS has been tracking and evaluating surveys to provide a basis for improvement activities. Although we have been improving over time in meeting patients' expectations, four target areas were chosen for improvement in 1999; education, visit coordination, emotion support and preferences. We achieved improved satisfaction scores in three of our four target areas. We remain committed to improving in all dimensions of care and use the overall problem score of 14% as our goal for 2001. A 14% overall problem score is consistent with our community benchmark and our VISN performance measure. Comparison scores from the Annual National Survey are as follows:

Performance Comparison:

Standard	1998	1999	2000	2000/2
Access	10%	11.43%	11.53%	11.11%
Courtesy	7%	6.65%	7.93%	6.65%
Coordination	19%	16.86%	18.27%	17.37%
Education	26%	27.92%	31.11%	26.83%
Preferences	20%	18.23%	20.65%	18.38%
Support	19%	18.51%	18.82%	17.77%
AVERAGE	**16.83%**	**16.60%**	**18.05%**	**16.35%**

Note: The percentages reflect problem rates, therefore, the lower the percentage, the higher the rate of satisfaction.

Another source of VAPAHCS patient assessments is the Patient Advocacy Program that collects and assesses patient complaints and compliments for trends. Information from our Veteran Service Organizations is evaluated for trends in patient feedback. Currently our major objective is to improve access to care and to improve our educational efforts in enhancing patient and family understanding of the patient's health care needs.

Employee Assessment

During the last five years, VAPAHCS has used the Malcolm Baldrige National Quality Award Criteria as the foundation of our employee assessment of performance improvement. We have found that employees want to be more involved and empowered in their roles. We have made major improvements in the first three years and are continuing to find new and improved methods to measure and improve employee satisfaction.

Education

- Section 5

Employees

VAPAHCS offers education and training to employees with the primary purpose of achieving the department's mission and performance goals. VAPAHCS is committed to providing opportunities for training, growth and development to all employees. A comprehensive education and training program facilitates recruitment, development and retention of dedicated and competent employees. It is through a capable workforce that VAPAHCS can respond effectively and efficiently to the needs of our veteran patients and their dependents.

Educational Strategies

Current and future educational strategies at VAPAHCS will include the following:

- Assuring employees understand their contributions to the VAPAHCS mission;
- Coordinating with the VA Employee Education System (EES) to develop quality training programs and disseminate them efficiently to the intended audience;
- Administering oversight of education and training activities to assure they are conducted in a coordinated manner;
- Allocating and administering of available funds in an effective and efficient manner to promote quality education and training of health care system personnel;
- Developing and using both existing and new learning resources and instructional technology available to all VAPAHCS employees;
- Coordinating with Human Resources Management Service the development of a comprehensive education plan for VAPAHCS to avoid redundancy and promote the effective use of resources;
- Ensuring that 60% of staff receives at least 40 hours of continuing education in FY 2002.

Education (cont'd)

- Section 5

Residents, Students, and Associated Health Trainees

VAPAHCS provides outstanding academic and research training programs for a wide range of individuals seeking education in a health care environment. This educational experience is provided through affiliations with the Stanford University School of Medicine and other distinguished educational institutions. In addition to providing an educational experience for residents, students, and trainees, our affiliation with educational institutions contributes to continued excellence in VA patient care.

Educational Strategies

Current and future educational strategies at VAPAHCS must include the following:

- Take a leadership role in shaping the educational experience of future healthcare professionals to meet the needs of an ever changing and complex national healthcare delivery system
- Foster an environment of learning and technological advancement for all residents, students, and trainees;
- Review the results of the annual survey of resident satisfaction and address the identified deficiencies.

Patients

The primary goal of the VAPAHCS Patient Education Program is to optimize patient involvement in their care. Patients need understandable information regarding their treatment plans and need to be empowered as partners in their care. Ideally, patient education efforts promote compliance with realistic care management plans and improved patient outcomes.

Educational Strategies

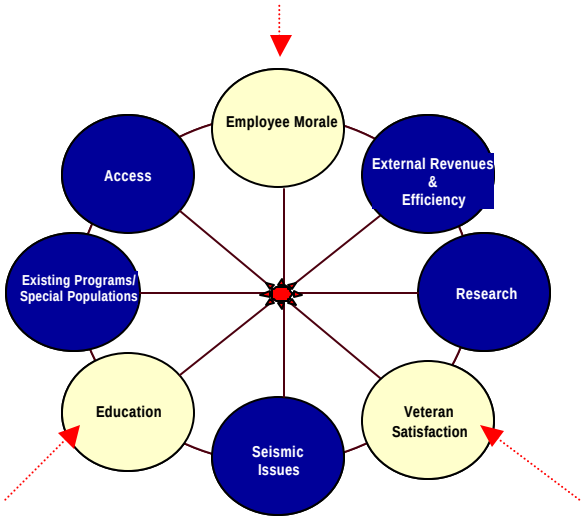
Current and future educational strategies at VAPAHCS must include the following:

- To assure that patients have access to the same quality information - continue standardizing patient education materials made available at all sites;
- Promote the use of patient educational materials at a reading level appropriate to the majority of patients;
- Standardize teaching outlines and promote the use of clinical guidelines;
- Promote provider documentation of educational exchanges in patient records as a means to reinforce patient education;
- Institute a quarterly patient newsletter, "To Your Health," covering health topics and information designed to empower patients;
- Conduct patient surveys to focus queries toward issues important to patients;
- Familiarize new and current employees with the Patient Education Program.

Communication – Public Affairs

- Section 6: Overview

VAPAHCS is committed to the principle that successful achievement of goals is dependent to a large extent on the involvement of our stakeholders. We have been proactive in developing programs that foster employee involvement. We continue to make every effort possible to inform staff and patients about relevant topics. VAPAHCS implemented many new initiatives in order to provide valuable information to our patients and staff. Part of our 8-Point Program focuses on veteran satisfaction, employee morale, and patient/staff education.



Town Halls: Under new executive leadership, the VAPAHCS engaged employees at every site. In fiscal year 2001, the executive leadership team traveled to each location to conduct town hall meetings with question and answer sessions. These activities provided valuable information to employees and allowed them to ask questions and offer recommendations. Town hall meetings are held bi-annually.

The Epicenter: In fiscal year 2001, VAPAHCS revitalized its newsletter committee to ensure that the newsletter was timely, informative and widely distributed. As part of this effort, the newsletter was re-named following a "name-the-newsletter" contest. *The Epicenter* is now a newly anticipated and widely read publication among staff and patients.

Stakeholders Meeting: The VAPAHCS actively involves its stakeholder in strategic planning. Executive leadership discusses all programmatic changes with its stakeholders. These meetings involve:

- *Monthly veteran service officer meetings*
- *Bi-monthly Congressional liaison meetings*
- *Quarterly veteran service and civic organizations (VAVS) meetings*
- *Employee forums*

Stakeholders provide information regarding proposals and veteran concerns while VA leadership discusses fiscal and health care system issues that maybe of interest to veterans.

Goal Sharing: In fiscal year 2001, VAPAHCS invited all employees to participate in meeting our first priority: increasing veteran enrollment. Following a goal sharing retreat, services appointed goal sharing coordinators, submitted plans, provided quarterly updates, and ultimately were rewarded for their participation through special contribution awards and through a goal sharing recognition ceremony.

Customer Satisfaction Surveys: We are actively involved with listening to employee and veteran concerns. Surveys are conducted to determine how we can best serve our stakeholders. Surveys include:

- *Veterans: In 2001, we achieved improved patient satisfaction scores in three of our four target areas*
- *Employees: Employees leave for a variety of reasons and their feedback is critical for us to obtain the pulse of employee morale. Each year, we conduct exit surveys to determine what areas need improvement*

Patient Material: Each year, the VAPAHCS implements new programs to assist employees with understanding health related issues. To assist in this effort, the VAPAHCS distributes "Health Wise" books to veterans. This material provides information to veterans regarding health related issues. In fiscal year 2001, a pilot program was implemented to assist veterans with their current medical conditions. Patient handbooks were developed for each veteran who was enrolled in the San Jose Clinic. The VAPAHCS will evaluate this program to determine whether or not this program should be rolled out across the entire health care system.

Communication - Public Affairs (cont'd)

- Section 6: Awards and Accomplishments

The VAPAHCS has a lot to be proud of. From receiving one of the top hospital ratings in the State of California (PEP-C), to empowering our employees to help our system achieve enrollment objectives, the VAPAHCS is a truly world-class integrated health care delivery system.

The key to our success is our approach. The secret to our success is our people. The VAPAHCS has some of the best clinicians, paraprofessionals, and administrative staff in the VHA. Our success is tangible. Our awards and accomplishments are numerous. Few academic medical centers have the depth and breadth of our clinical team. While many staff members receive the awards for their hard work, in the end, it is our veterans who reap the results of our accomplishments. As the result of many of these awards, our veterans receive top-notch medical care in a state-of-the-art treatment facility.

We believe that our veterans appreciate the care that they receive. As enrollment at other VA medical centers decline, we anticipate continued growth in our veteran populations. We intend to expand our outpatient services and several community clinics in anticipation that veterans will continue to return for their medical care.

While it is true that we offer our veterans world-class medical care, we, too, are extremely involved in the research side of medicine. The VAPAHCS has one of the largest research programs in the VA. Just like our clinical staff, our research staff has also received a number of kudos. Our research programs in mental health and geriatrics are important facets of our health care system. These programs contribute valuable tools and new techniques in support of our patient population. Our veterans receive innovative medical care based on the latest available research.

The following chart depicts a number of our most recent accomplishments. As new achievements are garnered, we will ensure that those individuals are recognized for their profound efforts. We are proud of all our staff and we will continue to ensure that our veterans receive the world-class care that they deserve.

- Received "3 Star" PEP-C rating (2001)
- Centers of Excellence (2001):
  - HIV & Domiciliary
- William Middleton Award for achievements in the field of immunology (2000)
- Mark Wolcott Award for Clinical Excellence (2000)
- Olin Tiege Award for Blind Center Mobility Program (2000)
- Under Secretary of Health Innovations Award - diabetes care Automated Telephone Disease Management (ATDM) (2000)
- Top VA hospital in FY01 for:
  - Prevention Index
  - Clinical Practice Guidelines (CPGs)
- The first Center of Quality Management in HIV Care
- One of four Patient Safety Centers of Inquiry in the VA
  - New Patient Simulation Center
- Circle of Life Award from the American Hospital Association for our Hospice Program (2001)
- Specialized Treatment Service (STS):
  - Cardiac Transplant Program
- Awarded one of five Mental Illness Research & Education and Clinical Centers (MIRECC) program in the VA
- One of the original Geriatric Research & Education and Clinical Centers (GRECC) in the VA
- "Most Wired" – top l00 hospitals in the US for IT (2001)
- One of the largest research programs in the VA (2001):
  - $13.8 Million VA Funding
  - $19.4 Million Non-VA Funding (i.e. NIH)
- Emphasis on "Goal Sharing" partnership with staff

Communication – Public Affairs (cont'd)

- Section 6: Awards and Accomplishments - Definitions and Explanations

The VAPAHCS have made significant contributions to our local communities. The awards and accomplishments are well deserved. This page of our Strategic Plan is reserved to explain what our accomplishments mean and why they are so important. While our staff receives literally hundreds of accomplishments each year, we were only able to mention a few within this Strategic Plan. Each award, whether it is mentioned within this document or not, is well deserved. The VAPAHCS wants to congratulate and thank all of its employees for a job well done. Our people have become so important to the continued successes of our healthcare system. The VAPAHCS would not be what it is today, a world-class academic health care center, without the contributions from our staff. Our motto, *"Excellence by Design"* is well deserved. OUR sincerest thanks goes out to the employees and their families for a job well done.

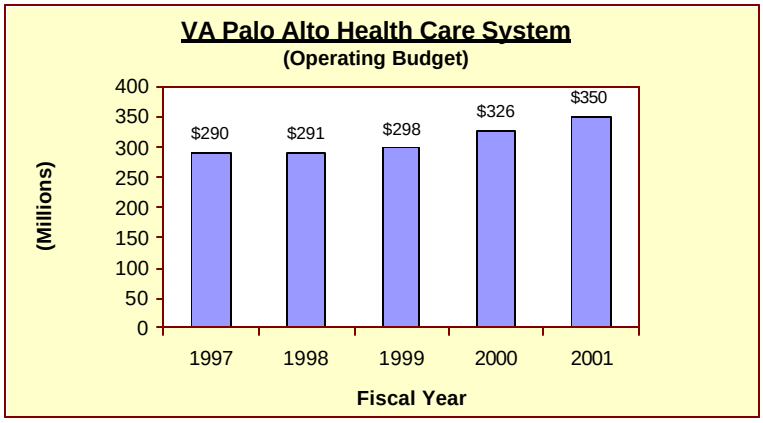
❖ Received "3 Star" PEP-C rating (2001)	Patients Evaluation of Performance in California (PEP-C). When benchmarked to other participating hospitals, the VAPAHCS received the highest possible rating
❖ Centers of Excellence (2001): • HIV & Domiciliary	Meeting stringent performance criteria, both our HIV and Domiciliary programs were recognized by VHA as "Centers of Excellence"
❖ William Middleton Award for achievements in the field of immunology (2000)	Eugene C. Butcher, MD, Director of the Serology and Immunology Section, Pathology, and Laboratory Service, was recognized for achievements in the field of immunology
❖ Mark Wolcott Award for Clinical Excellence (2000)	George Sullivan, MD, Assistant Chief, Spinal Cord Injury Service, was the recipient of the Mark Wolcott Award recognized for clinical excellence
❖ Olin Tiege Award for Blind Center Mobility Program (2000)	Members of the Orientation and Mobility Dept. of the Western Blind Center received the 20th annual Olin E. Teague Award for achievements in rehabilitation of war-injured vets
❖ Under Secretary of Health Innovations Award - diabetes care Automated Telephone Disease Management (ATDM) (2000)	VAPAHCS Diabetes Care Automated Telephone Disease Management Program received the Under Secretary of Health Innovations Award in 2000
❖ Top VA hospital in FY01 for: • Prevention Index • Clinical Practice Guidelines (CPGs)	Highest and/or most improved scores nationally for Clinical Practice Guidelines and Prevention Index
❖The first Center of Quality Management in HIV Care	1st Center of Quality Management in HIV Care opened in 2000. Program operates with the goal of creating state-of-the-art therapies, technologies and strategies for HIV veterans
❖ One of four Patient Safety Centers of Inquiry in the VA • New Patient Simulation Center	1-of-4 Patient Safety Centers of Inquiry in VHA. Tracks of inquiry include teamwork and simulation training, effects of fatigue on clinicians and measure and improving safety
❖ Circle of Life Award from the American Hospital Association for our Hospice Program (2001)	Circle of Life Award received citation of merit that honors innovative programs, which have improved the care people receive near the end of their lives
❖ Specialized Treatment Service (STS): • Cardiac Transplant Program	VAPAHCS is one of two health care facilities in the nation chosen for Specialized Treatment Service by the DoD to provide cardiac surgeries to TRICARE patients
❖ Awarded one of five Mental Illness Research & Education and Clinical Centers (MIRECC) program in the VA	VAPAHCS' MIRECC Program is recognized as one of five Mental Illness Research, Education and Clinical Centers in VHA
❖ One of the original Geriatric Research & Education and Clinical Centers (GRECC) in the VA	VAPAHCS' GRECC Program continues to excel in geriatric research and education
❖ "Most Wired" – top l00 hospitals in the US for IT (2001)	"Most Wired" – one of 100 hospitals in the nation for using state-of-the-art technology to connect hospitals with patients, doctors, nurses, employees, payers and health plans
❖ One of the largest research programs in the VA (2001): • $13.8 Million VA Funding • $19.4 Million Non-VA Funding (i.e. NIH)	Our research funds continue to grow as our Principal Investigators (PI) continue to successfully achieve VA and Non-VA funding in support of their research protocols
❖ Emphasis on "Goal Sharing" partnership with staff	The "Goal Sharing" partnership was highly successful in meeting our #1 priority of increasing veteran enrollment. We anticipate using the goal sharing initiative again this year to improve employee morale

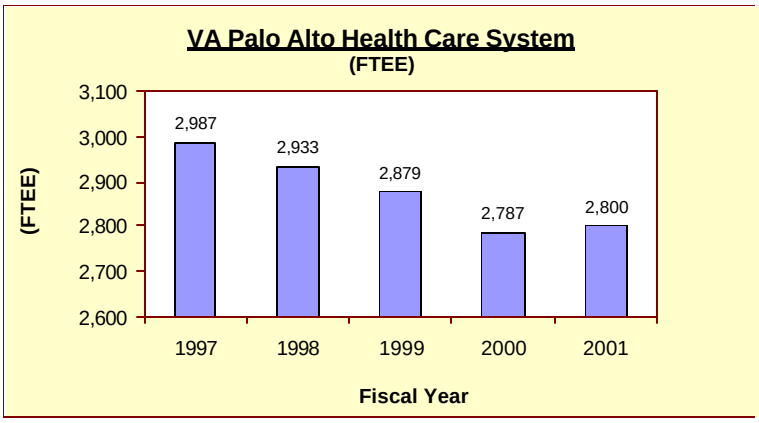
Financial and Capital Outlook

- Section 7: Fiscal Services, Operating Budget, and Staffing

Budget Overview

The VAHAHCS's FY 2001 operating budget totaled $350 million dollars, including $215 million in salary support and $126 million in supplies and services. The annual budget supports approximately 2,800 full time equivalent employees (FTEE) and 113 physician trainees. In addition, our health care system received over $32 million in FY 2000 for VA and non-VA funded research. Our operating budget and staffing over the previous four years (FY97-01) through FY 2001 is as follows:





Consistent with the goals of VA, VAPAHCS has been very successful in developing alternative sources of revenue amounting to over $11 million for FY 2000. Medical Care Collection Funds (MCCF) representing VA patient co-payments for inpatient, outpatient, pharmacy and third party payers remains the largest component and is expected to continue to grow due to implementation of billing based on reasonable charges. TRICARE collections for FY 2001 are expected to surpass $2.6 million as enrollment increases and all current active duty contracts fall under this umbrella. New sources of alternative revenue, which will be generated in FY 2000 - 2001, include agreements for Hospice/Respite and Specialized Treatment Services (open heart surgery). A summary of our alternative sources of revenue over the previous three years with a forecast for FY 2001 is the following:

Alternative Sources of Revenue

	1997	1998	1999	2000	2001
MCCF	$3,147,000	$5,414,000	$4,684,000	$5,851,000	$6,700,000
Sharing Agreements	$2,350,000	$3,560,000	$6,165,000	$4,665,388	$4,095,000
TRICARE	$250,000	$352,000	$440,000	$762,000	$2,600,000
(GRAND TOTAL)	$5,747,000	$9,326,000	$11,289,000	$11,278,388	$13,395,000

** Fiscal Year 2001 projections*

Financial and Capital Outlook

- Section 7: Construction and Facility Development Overview

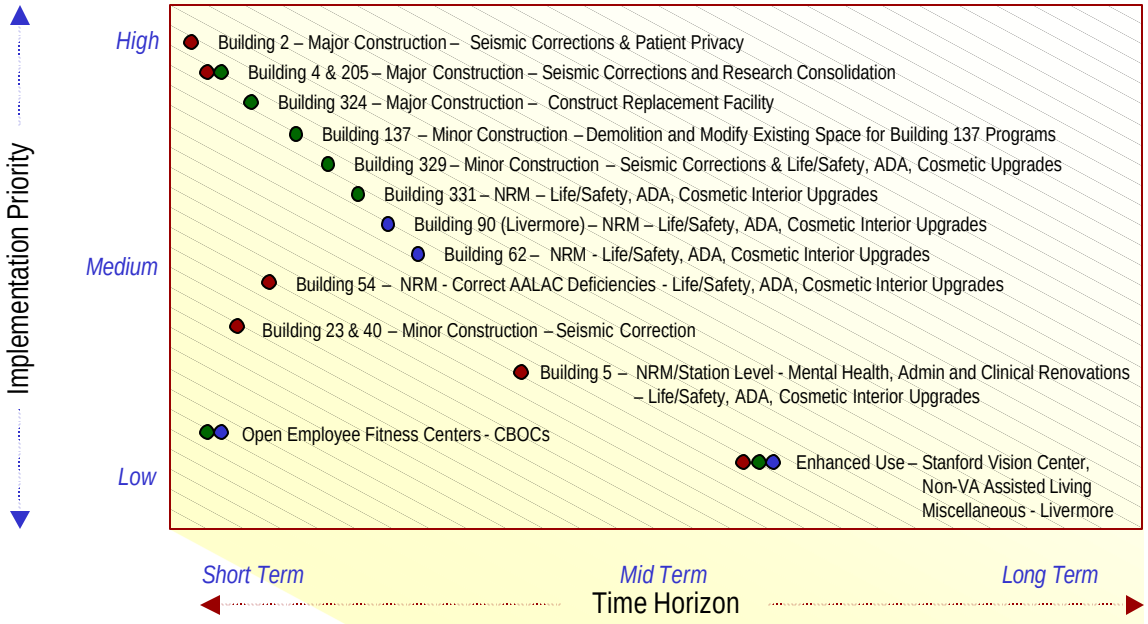
Our approved Facility Development Plan (FDP) has largely guided the principal renovation and construction goals of the VAPAHCS. This FDP has been updated regularly to reflect changes in tactical aspects of the plan, but the basic goals have not changed and continue to guide the VAPAHCS in developing and modifying our 5-year plan for construction.

FDP Primary Goals

- Correct Seismic deficiencies in all patient care buildings
- Correct patient privacy deficiencies in all inpatient settings
- Maintain acceptable environment of care standards in patient care settings
- Consolidate ambulatory services at Palo Alto Division
- Consolidate acute psychiatric services to Palo Alto Division
- Consolidate research programs to the Palo Alto Division

Consistent with these aforementioned goals, the following construction priorities are listed below:

Facility Development Time Horizon

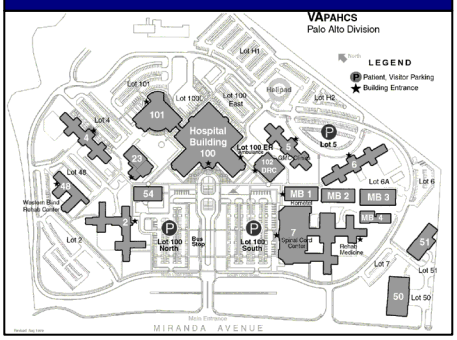


LEGEND

- Palo Alto Division
- Menlo Park Division
- Livermore Division

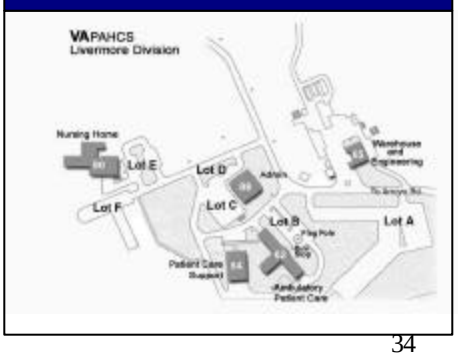
NOTE: Projects identified above are categorized by "Division" location. Projects are grouped by mission criticality. Projects are: Major, Minor, Non-Recurring Maintenance (NRM), and Station Level. All projects listed above, have a funding threshold surpassing $500K with the exception of the fitness centers. The fitness centers are included because of their importance - employee morale

Palo Alto Division



Menlo Park Division

Livermore Division



Financial and Capital Outlook (cont'd)

- Section 7: Palo Alto Division's Facility Development Plan

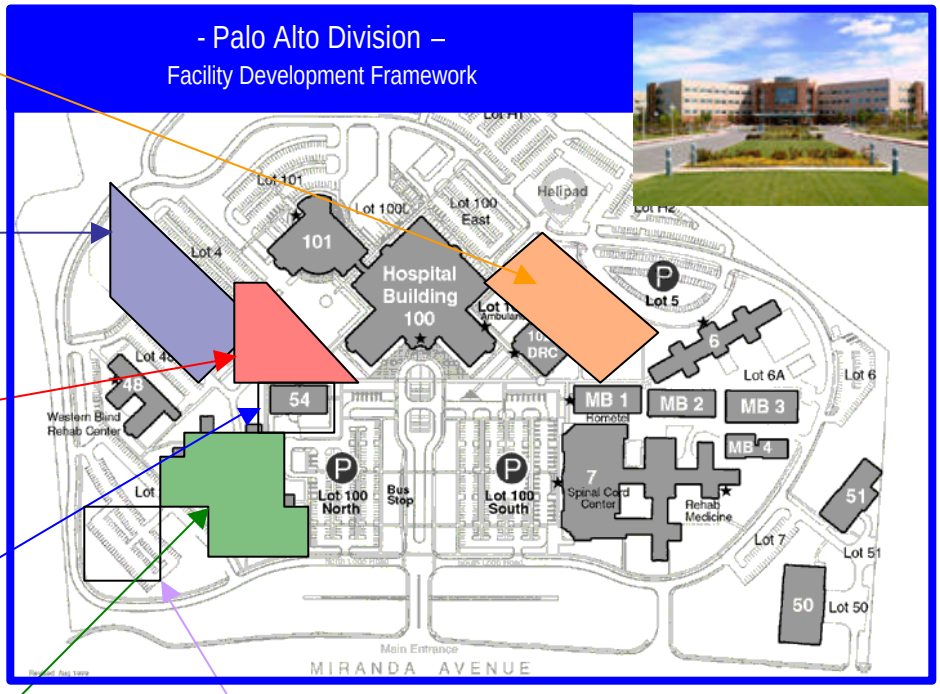
Building 5
Planned ~$5M Renovation – MIRECC, Primary Care, and Clinical Psychology
Anticipated Construction: FY02 – FY08

Building 4
Planned ~$22M Renovation – Seismic Mitigation and Research Consolidation
Anticipated Construction: FY03- 04

Building 23 & 40
Planned ~$1M Renovation – Seismic Mitigation and Functional Improvements
Anticipated Construction: FY03

Building 54
Planned $500K - 1M Renovation – Correct AAALAC Deficiencies – Veterinarian Bldg
Anticipated Construction: FY02 - FY03

Building 2
Planned ~$14M Renovation – Seismic Mitigation and Acute Psych Consolidation
Anticipated Construction: FY03 – FY04



Building X
Stanford University Vision Center
Anticipated Construction FY03

Building 2: Mitigate Building 2 (Acute Psychiatry) seismic and patient privacy deficiencies. Two patient care units, in Building 2 (2B1 and 2B2), were renovated in fiscal year 2001. Funding for the ~$14 million major construction project in fiscal year 2002 would correct seismic problems in the entire building and eliminate patient privacy deficiencies in the two remaining patient care units located on 2C1 and 2C2.

Building 4: Mitigate Building 4 (Research and GRECC) seismic deficiencies and consolidate all research functions located in the seismically deficient Building 205, at Menlo Park, into space within Building 4. This project will add additional dry and wet labs within Building 4 allowing for additional research lab space. In FY01, the last remaining Building 4 inpatient psychiatric unit was closed and patients were transferred to renovated inpatient psychiatric units.

Building 5: Building 5 was seismically corrected in the mid-1990s. Since its inception in 1960, the building was once used to house numerous inpatient acute psychiatric units. Currently, we are converting these former inpatient units to support our Mental Health research programs located on the fourth floor of Building 5. Over the next eight years, we will be renovating the interior of Building 5 to improve life/safety, ADA deficiencies, and to improve the interior décor.

Building 23 and 40: Mitigate Building 23 (Gymnasium and Therapeutic Pool) and Building 40 (Boiler Plant) seismic deficiencies. A project proposal was submitted to VAHQ for funding in FY01 to support corrective renovations. VA leadership supported the proposal to correct these two buildings. Project funding was provided at the end of FY 01 and construction will begin in the early part of fiscal year 2002.

Building 54: Building 54 has been identified as having numerous AAALAC deficiencies and we plan to fund this project in FY02 to ensure that we rectify any shortfalls that might impede our AAALAC accreditation.

Building X: Building X is the planned Stanford University Vision Center. Currently, this plot of land, under consideration, is a parking lot used by VA patients and staff. An enhanced use project with Stanford University supplement our facility budget and bring additional services to VA patients especially those patients who are part of our Western Blind Center.

Financial and Capital Outlook (cont'd)

- Section 7: Menlo Park Division's Facility Development Plan

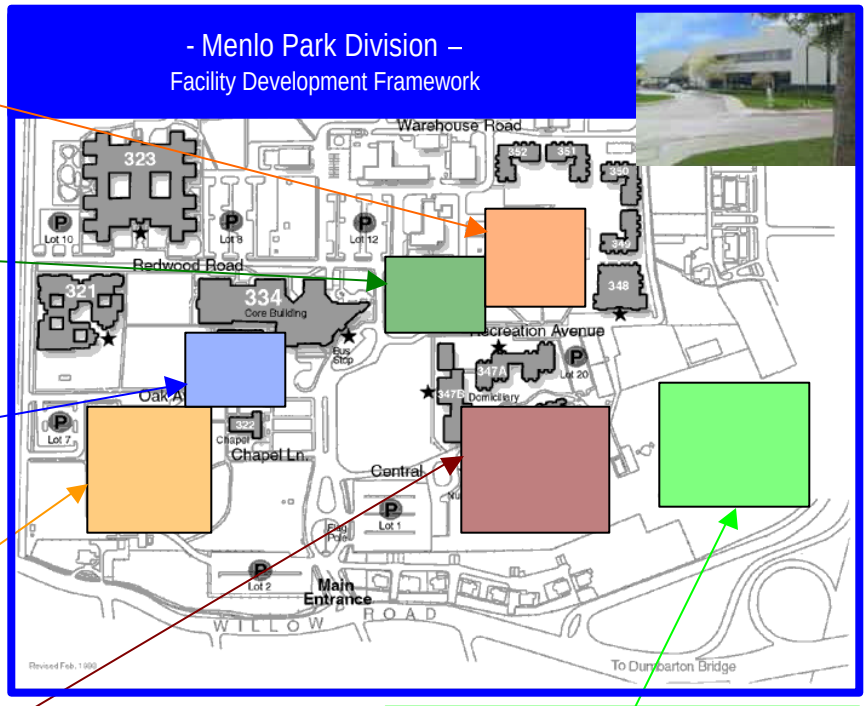
Building 137
Planned ~$4M Demolition and Relocation of Clinical and Administrative Functions
Anticipated Construction: FY02 - 03

Building 205
Planned ~$4M Demolition and Relocation of Clinical and Administrative Functions
Anticipated Construction: Unknown

Building 329
Planned ~$4M Renovation – Dietetic Food Production and Delivery Facility
Anticipated Construction: FY02 – FY03

Building 324
Planned ~$26M Replacement Building – Geropsych Nursing Home Unit
Anticipated Construction: Unknown

Building 331
Planned ~$3M Renovation - B and D Wing Nursing Home Units
Anticipated Construction: FY02 – FY03



Building Y
Planned Enhanced Use – Non-VA Nursing Home/Assisted Living Facility
Anticipated Construction: FY03

Building 137: Based on the numerous seismic and facility deficiencies, the VAHAHCS recommended demolition of Building 137 in FY02. Clinical and administrative functions would be relocated to a seismically safe building on the Menlo Park Campus.

Building 205: Based on the numerous seismic and facility deficiencies, the VAHAHCS recommended demolition of Building 205 in FY 2003 - 2004. Clinical and administrative functions would be relocated to a seismically safe building on the Palo Alto Campus once Building 4 becomes seismically retrofitted. The long-term plan is to populate Building 4, on the Palo Alto campus, with lab and research functions that are currently located in Building 205 on the Menlo Park Campus.

Building 329: Building 329 is responsible for preparing inpatient meals that support approximately 1,000 operating beds on all three divisions of the VAHAHCS: Palo Alto, Menlo Park, and Livermore. In 1995, consultants conducting a facility review of Building 329 identified "serious functional deficiencies" and "are undersized and outdated for its mission." In addition, Building 329 has numerous seismic deficiencies. We anticipate that this project, once funded, will mitigate all known deficiencies (life/safety, ADA, seismic, and functional).

Building 329: We will continue our efforts to secure funding to replace Building 324. Our project proposal to replace Building 324 (Geropsychiatric Nursing Home) was ranked as the "Number One" construction priority for the VA in the FY 2001 construction budget; however, funding in FY01 never came to fruition.

Building 331: In FY 01, the 1st phase of the Building 331 (nursing home unit - C Wing) was renovated. The remaining two patient care units (B and D Wings) are included in the 2nd phase, which we anticipate will begin in fiscal year 2002.

Building Y: In accordance to our approved Enhanced Use Project Business Plan, a non-VA nursing home/assisted living facility will be constructed on the site of the current Menlo Park golf course. This project will bring in additional revenue to the VAHAHCS to augment our operating budget.

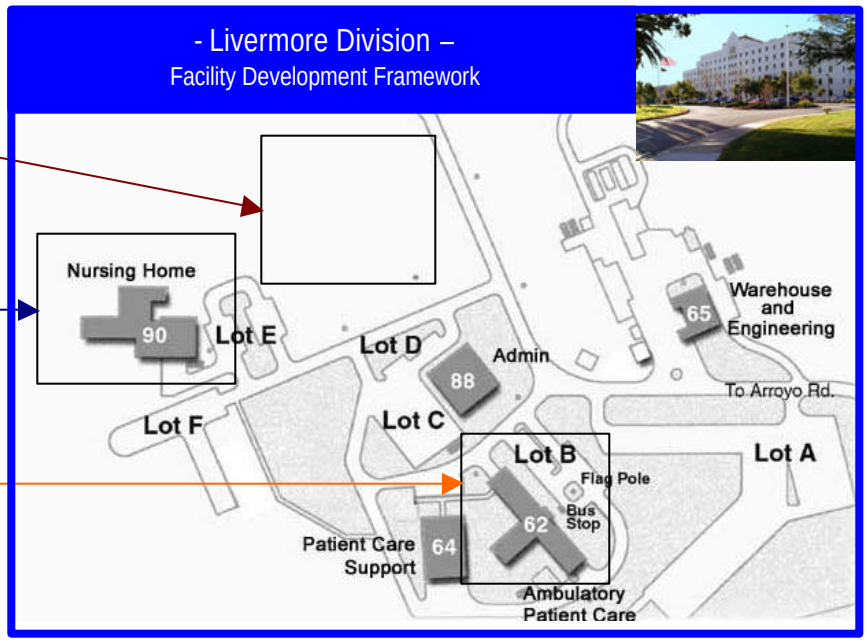
Financial and Capital Outlook (cont'd)

- Section 7: Livermore Division's Facility Development Plan

Building Z
Planned Enhanced Use Project. Identify Potential Partnerships
Anticipated Construction: Unknown

Building 90
Planned $3-4M Project to Overhaul 120-Bed Nursing Home Building
Anticipated Construction: FY02 - 04

Building 62
Planned ~$4M Renovation of Miscellaneous Functions (Roof, Waste Lines, Lobby, GI)
Anticipated Construction: FY02 - 04



Building Z: In accordance to our approved Enhanced Use Project Business Plan, the VAPAHCS has identified the former Livermore golf course, as shown above, as a potential site for revenue generation. Currently, the space is unused. This potential project would garner additional revenue for the VAPAHCS.

Building 90: Building 90, located on the Livermore Division, is a 120-bed long-term care nursing home unit. The building, which was built in 1980, has not been renovated since its inception. Eliminating facility structural deficiencies is our main concern. Building 90's foundation will be sealed to mitigate further water damage. Our project proposal will correct life/safety and ADA deficiencies. In addition, improving the interior décor and replacing outdated finishes to improve patient and employee-working conditions is also a top priority

Building 62: Building 62 was constructed as an inpatient hospital in 1949. In the mid-1990s, the Livermore VA Medical Center was incorporated into the VAHAHCS. Today, Building 62 is primarily an outpatient facility with a focus on primary, specialty and ancillary services. A 30-bed sub-acute inpatient unit is also housed in this facility. A number of Non-recurring Maintenance (NRM) and station level projects are planned to improve the décor of Building 62. In addition, we will improve the functional deficiencies, correct ADA and life/safety problems. These miscellaneous projects include:

- $1.4M fire alarm system (all Livermore buildings)
- $ 1M roof replacement to mitigate roof penetrations and aging roof
- $1M waste line replacement for East Wing of Building 62 – Building 62 has 5 separate roofs
- $400K main lobby and bathroom renovation
- $150K GI suite construction

Numerous projects will be completed on the Livermore Division within the next 5 years:

- Re-key the entire Livermore Division
- Continue efforts to mitigate asbestos
- Install an Advanced Tray Delivery System – 'A la Cart' initiative
- Build an employee fitness center
- Refinish windows (Building 88)
- Paint reservoir to mitigate lead contamination
- Demo miscellaneous dilapidated structures – support buildings

FY 2001 VISN 21 Goals & Performance Measures

- Section 8: VAPAHCS Performance Results (Overview)

Modern health care organizations are increasingly held to performance standards, which can be measured, tracked and standardized for comparison to peer organizations. The Department of Veterans Affairs is by no means an exception. To the contrary, VA hospitals are held to performance standards, which are at least as rigorous, if not more than our community colleagues. These performance standards, developed at the National and Network levels, are negotiated at the facility level as measurable performance targets we are expected to meet. The performance standards are relevant to the goals and Strategic Plans of the VHA, Network and Facility. The VISN 21 fiscal year 2001 targets are listed below:

VISN 21 FY01 Goals	Performance Measure	FY01 Target		FY01 Performance		
		Fully Successful	Exceptional	1st Qrtr	2nd Qrtr	3rd Qrtr
Quality	Prevention Index (PI)	78%	83%	95%	91%	90%
	Clinical Practice Guidelines (CPGs)	Quad II or IV	Quad I	Quad I	Quad I	Quad I
	SCI Discharges	95%	99%	No Data	100%	99%
	SCI Satisfaction Survey	60%	75%	No Data	No Data	No Data
	Veterans Satisfaction Survey (VSS)	Meet All	Meet All	Close	Close	Close
	Patient Education	Reduce 1%	Reduce 2%	26.8%	26.8%	26.8%
	Visit Coordination	Reduce 1%	Reduce 2%	17.4%	17.4%	17.4%
	Pharmacy Waiting Times	Reduce .5%	Reduce 1%	13.1%	13.1%	13.1%
	LTC Depression Action Plan	90%		100%	100%	100%
	JCAHO Survey Grid Score	90		No Data	No Data	No Data
Access	Increase **Vested** Category A (1 year)	1,447		No Data	1,308	1,140
	Non-vested Category A Patients	3%		No Data	5.3%	4.7%
	Increase Category A (1 year)	924		(690)	236	978
	Follow-Up Mental Health	80%	90%	76%	81%	81%
	Clinic Waiting Times	Meet All	Meet All	Not Met	Not Met	Not Met
	Audiology	45 days	30 days	15	18	12
	Cardiology	45 days	30 days	31	30	63
	Eye Care	45 days	30 days	50	70	55
	Orthopedics	45 days	30 days	24	31	36
	Primary Care	45 days	30 days	12	38	30
	Urology	45 days	30 days	23	29	42
	Provider Waiting Times	25%	18%	19.4%	19.4%	19.4%
	SCI Staffing Levels	43 beds	N/A	Close	Met	Met
Efficiency	Increase MCCF Collections	$6.0M		$1.2M	$3.3M	$5.1M
	Increase Other External Revenues	$5.0M		$1.2M	$2.4M	$4.6M
	Means Test Audits (signatures)	95%		99%	90%	96%
	Adherence to Budget Plan	Yes		Yes	Yes	Yes
	Total Cost/DRG (088=COPD)	$6,340		No Data	$6,618	
	Rx Cost/Hyperlipidemic Pt	$49.11		$54.13	$54,84	$4,600
	Prosthetics Inventory Program Usage	95%		63%	90%	100%
	Prosthetics Delayed Orders	2%		6%	4%	1%
Special Emphasis Issues	50% Employees Receive	50% (40 hrs)		23% (11% PS)	31% 23% PS	50% 50%
	Hepatitis C Screening	70%		59%	84%	82%
	Reduce LTCR	< 2.68		No Data	No Data	67--69
	C&P Exams Timeliness	<= 35 days		22	20	20
	C&P Electronic Transmissions	90%		100%	100%	100%
	Root Cause Analysis Timeliness	95%	Practice Change	Met/Met	Met/Met	Met/Met
	Resident Supervision Audit	90%		Due 4Q	Due 4Q	70%
	Homeless Outreach	150 Form X/SW	45 new pts/SW	89/57	192/113	319/184
	ASI (Initial and Follow-up)	90%		No Data	32%/1%	52%/6%
	HPDM Implementation	All Modules		Due 2Q	Met	Met

FY 2001 VISN 21 Goals & Performance Measures (cont'd)

- Section 8: VAPAHCS Performance Results (Quality)

The VAPAHCS has been highly successful in accomplishing VISN 21 fiscal year 2001 "Quality" objectives. The VISN Director identified the following "Performance Measures" as health care system priorities for fiscal year 2001. Although the fourth quarter results have not yet been completed, the VAPAHCS is confident that it will meet and/or exceed these performance targets. The JCAHO survey is the last remaining objective to accomplish.

VISN 21 Performance Priorities

- Veteran Satisfaction Survey (VSS)
- Prevention Index (PI)
- JCAHO Survey Grid Score
- Clinical Practice Guidelines

VISN 21 Score Card

- Exceptional
- Pending Completion
- Fail - Unsuccessful

VA Palo Alto FY01 Objectives

VISN 21 FY01 Goals	Performance Measure	Performance Baselines			FY01 Target		FY01 Performance		
		FY98	FY99	FY00	Fully Successful	Exceptional	1st Qrtr	2nd Qrtr	3rd Qrtr
Quality	Prevention Index (PI)	58%	81%	93%*	78%	83%	95%	91%	90%
	Clinical Practice Guidelines (CPGs)		Not Met	Quad 1	Quad II or IV	Quad I	Quad I	Quad I	Quad I
	SCI Discharges		58%	99%	95%	99%	No Data	100%	99%
	SCI Satisfaction Survey			64%	60%	75%	No Data	No Data	No Data
	Veterans Satisfaction Survey (VSS)				Meet All	Meet All	Close	Close	Close
	Patient Education			31.1%	Reduce 1%	Reduce 2%	26.8%	26.8%	26.8%
	Visit Coordination			18.3%	Reduce 1%	Reduce 2%	17.4%	17.4%	17.4%
	Pharmacy Waiting Times			15.7%	Reduce .5%	Reduce 1%	13.1%	13.1%	13.1%
	LTC Depression Action Plan				90%		100%	100%	100%
	JCAHO Survey Grid Score			98	90		No Data	No Data	No Data

Performance Measure Scorecard - Definitions

Performance Index*: This index consists of nine medical interventions that measure how well VHA follows nationally recognized primary prevention and early detection for the following nine diseases with major social consequences. By Sep 30, 2001, the performance on the PI will increase (influenza immunization, Pneumococcal immunization, tobacco screening, alcohol screening, screening for hyperlipidemia, screening for breast cancer, screening for cervical cancer, screening for colorectal cancer, prostate cancer education)

Clinical Practice Guidelines*: Nationally developed clinical practice guidelines for the following diseases. By Sep 30, 2001, VISNs have implemented the following modules of guidelines and performance will increase [Ischemic Heart Disease (IHD), Congestive Heart Failure (CHF), Diabetes Mellitus (DM), Tobacco Use Cessation, Chronic Obstructive Pulmonary Disease (COPD), Major Depressive Disease (MDD), and Schizophrenia]

SCI Discharges: Discharges from Spinal Cord Injury bed section to a non-institutional care setting, including another VA hospital, nursing home, domiciliary, penal institution, or respite care. By Sep 30, 2001, increase percentage of discharges from a SCI bed section to a non-institutional care setting

SCI Satisfaction Survey: Recently discharged inpatients will report their health care as very good to excellent on the VA National Satisfaction Survey. By Sep 30, 2001, percentage of SCI&D inpatients who report their VA care as very good to excellent on VA National Patient Feedback Center Satisfaction Inpatient SCI Survey will increase

Veteran Satisfaction Survey (VSS)*: A non-VA benchmark survey tool used by the non profit Picker Institute for Patient Centered Patient Care that measures problem rates related to standardized dimensions of care. Performance measure dimensions of care are: Patient Education, Visit Coordination and Pharmacy Wait Times. By Sep 30, 2001, the average number of Veterans Health Service Standard (VHSS) problems reported per patient for the patient education, visit coordination and pharmacy categories will decrease

LTC Depressions Action Plan: All LTC patients will be assessed for depression

JCAHO Survey Grid Score*: Triennial survey scores will be 90 or above

** Indicated VISN 21 Director's Performance Priorities*

FY 2001 VISN 21 Goals & Performance Measures (cont'd)

- Section 8: VAPAHCS Performance Results (Access)

The VAPAHCS continues to focus its efforts on increasing new Category A patients. In fiscal year 2001, we anticipate a total of 32,000 Category A patients.

Although the fourth quarter results have not yet been tabulated, the VAPAHCS is confident that we will meet and/or exceed these performance targets for clinic wait times. Significant effort has been made to achieve the wait time objectives for the following clinics: (see below)

VISN 21 Performance Priorities

- Increase Vested 'Category A' Patients
- Clinic Waiting Times
- Provider Waiting Times

VISN 21 Score Card

- Exceptional
- Pending Completion
- Fail - Unsuccessful

VA Palo Alto FY01 Objectives

VISN 21 FY01 Goals	Performance Measure	Performance Baselines			FY01 Target		FY01 Performance		
		FY98	FY99	FY00	Fully Successful	Exceptional	1st Qrtr	2nd Qrtr	3rd Qrtr
Access	Increase **Vested** Category A (1 year)			28,936	1,447		No Data	1,308	1,140
	Non-vested Category A Patients			6.0%	3%		No Data	5.3%	4.7%
	Increase Category A (1 year)	29,988	30,706	30,790	924		(690)	236	978
	Follow-Up Mental Health	75%	85%	83%	80%	90%	76%	81%	81%
	Clinic Waiting Times			Not Met	Meet All	Meet All	Not Met	Not Met	Not Met
	Audiology			42	45 days	30 days	15	18	12
	Cardiology			33	45 days	30 days	31	30	63
	Eye Care			58	45 days	30 days	50	70	55
	Orthopedics			16	45 days	30 days	24	31	36
	Primary Care			20	45 days	30 days	12	38	30
	Urology			23	45 days	30 days	23	29	42
	Provider Waiting Times			22.9%	25%	18%	19.4%	19.4%	19.4%
	SCI Staffing Levels			Not Met	43 beds	N/A	Close	Met	Met

Performance Measure Scorecard - Definitions

Increase Vested Category A (1 year)*: Goal to increase the number of newly vested Category A patients compared to previous year. Identifies increased access of veterans to healthcare benefits

Non-vested Category A Patients: (same)

Increase Category A (1 Year)*: (same)

Follow-up Mental Health: By Sep 30, 2001, patients discharged for mental health disorders will receive outpatient care related to mental health within 30 days following discharge

Clinic Wait Times*: By Sep 30, 2001, the average waiting time will decrease for the following DSS identifier categories (clinics): eye care, audiology, orthopedics, cardiology, urology, and primary care

Audiology: Audiolgy wait time for fully successful: less than 45 days; exceptional less than 30 days
Cardiology: Cardiology wait time for fully successful: less than 45 days; exceptional less than 30 days
Eye Clinic: Eye Clinic wait time for fully successful: less than 45 days; exceptional less than 30 days
Orthopedics: Orthopedics wait time for fully successful: less than 45 days; exceptional less than 30 days
Primary Care: Primary Care wait time for fully successful: less than 45 days; exceptional less than 30 days
Urology: Cardiology wait time for fully successful: less than 45 days; exceptional less than 30 days

Provider Waiting Times*: Provider wait times will not exceed 20 minutes. This goal has been stretched over the past few years, as a decrease in wait time is very important to our patients. By Sep 30, 2001, percentage of patients who report in the VA's National Veterans Health Care Satisfaction Ambulatory Care Survey waiting for a provider more than 20 minutes will decrease

SCI Staffing Levels: A minimally staff to patient ratio has been identified as a high priority by veterans groups. Beds and staffing at each SCI Center will meet or exceed the levels specified in VHA Directive 200-2002 by January 31, 2001

** Indicated VISN 21 Director's Performance Priorities*

FY 2001 VISN 21 Goals & Performance Measures (cont'd)

- Section 8: VAPAHCS Performance Results (Efficiency)

The VAPAHCS has had a tremendous year in terms of accomplishing our "efficiency" measures. As outlined in Section 7 of this document (Fiscal and Capital Outlook), the MCCF collections far exceeded all expectations. We anticipate collecting in excess of $6.8M – over a million dollars more than last fiscal year.

With regard to the $350M VAPAHCS operating budget, we anticipate carrying over $10M to cover anticipated shortfalls in fiscal year 2002 budget projections.

VISN 21 Performance Priorities

- Increase Medical Care Collection Funds (MCCF)
- Adherence to Budget Plan

VISN 21 Score Card

- Exceptional
- Pending Completion
- Fail - Unsuccessful

VA Palo Alto FY01 Objectives

VISN 21 FY01 Goals	Performance Measure	Performance Baselines			FY01 Target		FY01 Performance		
		FY98	FY99	FY00	Fully Successful	Exceptional	1st Qrtr	2nd Qrtr	3rd Qrtr
Efficiency	Increase MCCF Collections	$1.2M	$4.5M	$5.6M	$6.0M		$1.2M	$3.3M	$5.1M
	Increase Other External Revenues	$133k	$4.5M	$5.5M	$5.0M		$1.2M	$2.4M	$4.6M
	Means Test Audits (signatures)				95%		99%	90%	96%
	Adherence to Budget Plan			Yes	Yes		Yes	Yes	Yes
	Total Cost/DRG (088=COPD)			$6,674	$6,340		No Data	$6,618	
	Rx Cost/Hyperlipidemic Pt			$54.57	$49.11		$54.13	$54.84	$4,600
	Prosthetics Inventory Program Usage			21%	95%		63%	90%	100%
	Prosthetics Delayed Orders		0%	1.4%	2%		6%	4%	1%

Performance Measure Scorecard - Definitions

Increase MCCF Collections*: Efficiency and compliance in billing procedures is of high priority. Third party revenues are essential to our financial viability

Increase Other External Revenues: Same as above. External revenues allow us to take advantage of excess capacity to increase available resources used to provide additional benefits to veterans

Means Test Audits (signatures): To provide veterans their eligibility status accurately and timely, as well as identifies Category A veterans

Adherence to Budget Plan*: Of major importance for our continuing function. Maintain control of our local budget is essential

Total Cost/DRG (088=COPD): Establishes a patient care cost benchmark for a specific patient population

Rx Cost/Hyperlipidemic Patient: Establishes a benchmark for pharmacological cost of patient care for a specific population

Prosthetics Inventory Program Usage: Guarantees adequate stock while not tying up resources unnecessarily

Prosthetics Delayed Orders: Provides the highest level of service to our veterans

** Indicated VISN 21 Director's Performance Priorities*

FY 2001 VISN 21 Goals & Performance Measures (cont'd)

- Section 8: VAPAHCS Performance Results (Special Emphasis Issues)

The VAPAHCS continues to ensure that we accomplish all "Special Emphasis Issues." Our prevention Hepatitis C screening has shown noticeable results. Currently over 80% of our veterans have received Hepatitis C screening.

The VAPAHCS continues to meet and exceed the Compensation and Pension (C&P) exam timeliness targets. Currently, we are able to accomplish C&P exams in approximately 20 days – far exceeding the goal of <= 35 days.

The VAPAHCS anticipates accomplishing its resident supervision audits in fiscal year 2001.

VISN 21 Performance Priorities

- C&P Exams Timeliness

VISN 21 Score Card

- Exceptional
- Pending Completion
- Fail - Unsuccessful

VA Palo Alto FY01 Objectives

VISN 21 FY01 Goals	Performance Measure	Performance Baselines			FY01 Target		FY01 Performance		
		FY98	FY99	FY00	Fully Successful	Exceptional	1st Qtr	2nd Qtr	3rd Qtr
Special Emphasis Issues	50% Employees Receive	54 (20 hrs)	3% (30 hrs	8% (40 hrs	50% (40 hrs)		23% (11% PS	31% 23% PS	50%50%
	Hepatitis C Screening				70%		59%	84%	82%
	Reduce LTCR	4.1	3.0	2.3	< 2.68		No Data	No Data	67–69
	C&P Exams Timeliness	31	22	17	<= 35 days		22	20	20
	C&P Electronic Transmissions				90%		100%	100%	100%
	Root Cause Analysis Timeliness				95%	Practice Change	Met/Met	Met/Met	Met/Met
	Resident Supervision Audit				90%		Due 4Q	Due 4Q	70%
	Homeless Outreach				150 Form X/SW	45 new pts/SW	89/57	192/113	319/184
	ASI (Initial and Follow-up)				90%		No Data	32%/1%	52%/6%
	HPDM Implementation			Met	All Modules		Due 2Q	Met	Met

Performance Measure Scorecard - Definitions

50% Employees Receive 40-hours of Patient Safety Training: Emphasis on patient safety training as a way to ensure health care providers are well aware of the need to provide safe quality care to all veterans

Hepatitis C Screening: VHA has identified screening high–risk patients for Hepatitis C virus as a high priority. The goal is to provide treatment as appropriate

Reduce LTCR: Safety of our employees is a high priority. If we reduce the lost time claims rate we know we are reducing serious injuries and our main goal is a safer work environment for all of our stakeholders

C&P Exams Timeliness and Transmission*: We provide compensation and pension examinations for all veterans. Our goal is to do C&P exams within a reasonable timeframe and to transmit the results to the VBA as soon as possible

Root Cause Analysis Timeliness: Patient safety is a high priority. For this reason we have a short turnaround expectation for the analysis of adverse events

Resident Supervision Audit: We strive to improve resident supervision and its documentation. The goal, this year, is to have 90% of our records document resident supervision. This goal will increase to 100%

Homeless Outreach: Our veteran population includes a large number of indigent veterans. We are constantly trying to increase the number of these veterans who we can provide with basic health care. We also try to get veterans into programs to improve their life situations

ASI (Initial and Follow-up): This performance measure is being revised. The goal is to ensure effective identification of patients with addiction disorders and to provide follow up care to those patients

HPDM Implementation: It is VAPAHCS goal to have a uniform approach to management. Training is mandatory

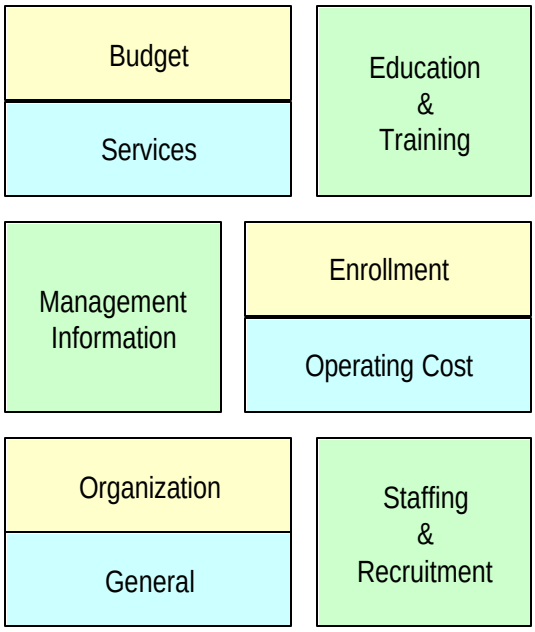
** Indicated VISN 21 Director's Performance Priorities*

Planning Assumptions

- Section 9

The VAPAHCS has identified a number of critical planning assumptions. These assumptions, outlined below, are reviewed annually. Each year, we determine whether the list should be modified. These assumptions are used for devising our strategic methodology. They are instrumental in developing strategic goals and objectives.

In fiscal year 2002, a number of new planning assumptions will be added to the existing list. As fiscal constraints perpetuate, we must utilize our scarce financial resources appropriately. Therefore, we will soon introduce a number of benchmarks to determine how and where we become more efficient. Efficiency and fiscal responsibility will be two key terms that we will add to our vocabulary.



BUDGET	• The current VERA model of resource distribution will not be substantially changed before the next budget cycle • The VHA budget will have difficulty keeping pace with health care inflation • There will be an increase reliance in VHA upon alternative revenue streams, i.e., MCCF and Medicare Subvention
EDUCATION AND TRAINING	• New administrative policies / requirements for residency supervision will be imposed in FY00/01 by VAHQ and regulatory bodies
ENROLLMENT	• Enrollment of new Category A veterans will become increasingly difficult. Our greatest potential is from the Valley
MANAGEMENT INFORMATION	• There will be a significant increase in the amount of accuracy of managerial and demographic data
OPERATING COST	• The cost of medical care will increase as a rate greater than the consumer price index (CPI) • Our medical school affiliation will suffer budgetary pressures greater than those anticipated for VAPAHCS. Therefore, there will be pressure from the affiliate to absorb an increasing share of the cost of education and associated clinical care.
ORGANIZATION	• The trend toward increased centralization of managerial authority at the VISN level will continue • VAHQ will likely establish additional special emphasis programs • Control of established special emphasis programs will be increas ingly centralized
SERVICES	• Demand for inpatient care will continue to show a bi-model distribution between critical care and sub-acute
STAFF AND RECRUITMENT	• Cost of living in the San Francisco Bay Area will continue to increase • The highest cost of living in the San Francisco Bay Area will cause staffing issues • The Central Valley is a difficult staffing environment particularly for physicians and certain other professional staff
GENERAL	• There will no major World wars

Fiscal Year 2000 – 2002 Strategic Goals

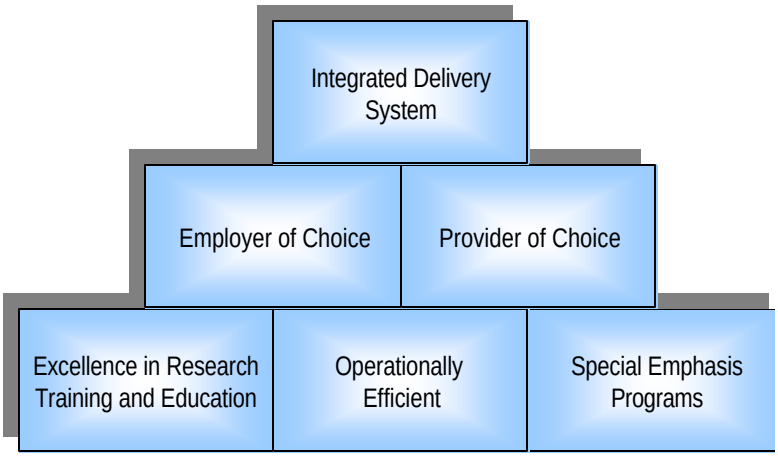
- Section 10: Strategic Goal (Overview)

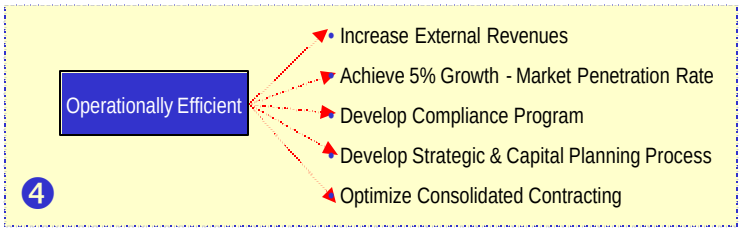
In 1999, the VAPAHCS identified six major strategic goals. Each individual goal has been integrated into our long-term strategic plan. These six goals, collectively, are vital for our continued success. They are:

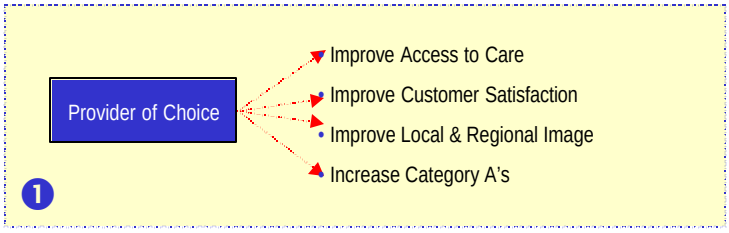
- Provider of Choice
- Employer of Choice
- Integrated Delivery System
- Operational Efficiency
- Special Emphasis Programs
- Excellence in Research, Training, and Education

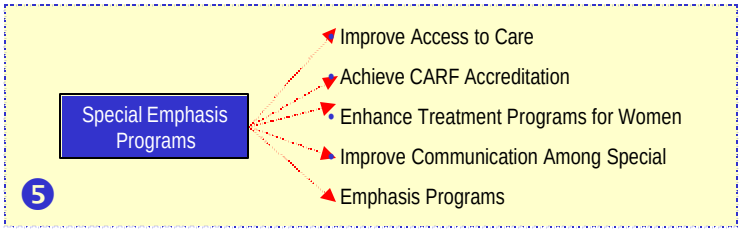
Section 10 of the VAPAHCS will review each of these strategic goals in detail. Tactical action and status reports are also included for your review. The tactical action section identifies how we intend to accomplish and achieve our strategic goals. The status report section explains whether specific events were successful in achieving our anticipated results.

The strategic goals will be reviewed in fiscal year 2002 as we begin a new round of strategic planning. At that time, we will identify whether or not the six strategic goals have achieved real outcomes. We will evaluate the results and determine what new goals and objectives are required. We want to ensure that the VA Palo Alto Health Care System remains a *World Class* integrated health care system.









Fiscal Year 2000 – 2002 Strategic Goals (cont'd)

- Section 10: Strategic Goal 1: Be a Provider of Choice for Veterans

Objectives	Tactical Actions	Status
A. Improve access to care.	1. Define the role and desirable expansion or contraction of CBOC services.	1. Measure panel size and provider to total enrollment ratio. 2. Measure the number of consultant from each site.
	2. Examine distribution of provider services to systematically equalize patient access to care.	1. Establish at what time you open a new CBOC. Use this to determine how and when we provide services beyond primary care. 2. Measure the number of consultants from certain sites. 3. Determine the number of unserved veterans in each site and develop a plan to meet their assessed needs.
	3. Explore implementation of IHI Access Model including development of referral criteria for each subspecialty.	1. Referral guidelines for each clinic and at what point each patient would be discharged from the clinic. 2. Plan of implementation of IHI principles in chosen clinics. 3. A monitoring system to determine effects of implementation plans.
B. Improve customer satisfaction	1. Improve Patient Retention	Run last patient list monthly - call patients falling off lists
	2. Insure that every patient has a designated provider or team responsible for managing his/her total care.	1. Continue work on PCMM and using data from Goal I.A.2. decide when and which providers are needed. 2. Educate teams/patients/providers on role and identity of designated providers.
	3. Improve processes to be more patient friendly, starting with a focus on enrollment, check-in, scheduling and billing processes.	Recently awarded contract to ECG Management Consultants, a firm specializing in identification and development of system improvement which impact upon third party billing and collections. In the first phase, ECG has identified patient scheduling, patient eligibility and patient registration as areas where the potential exists to improve performance. Based on the findings and recommendations of ECG, the MCCR Steering Committee has recommended that a contract (phase II) be awarded to ECG for the purpose of redesigning current systems to implement recommendations of phase I. The contract period should be 4 months from date of award.
	4. Develop and implement annual customer focus training for employees based on customer contact, I.e., level and intensity.	Annual customer service training will be developed in both classroom and web based form. Will attempt to implement as part of annual refresher training
	5. Develop customer contact requirements, relay to employees and hold employees accountable to meet.	Basic contact requirements will be developed. Will negotiate for relay and accountability by employees.
	6. Develop written materials that simplify explaining the basics regarding eligibility. Distribute to all VAPAHCS employees and veterans.	43 page reference book "VA Healthcare Services 2000 Edition" which provides information about veteran and TRICARE eligibility, enrollment, and available services. This reference is given to all veterans at the time of their enrollment as well as to employees seeking information about eligibility, registration and/or co-payment responsibility. Funding request will be made for additional copies that will be distributed to all employees.
	7. Using the IHI principles, include patients when scheduling future appointments. Ensure the appointment loc. is clearly understood by both scheduler and patient.	1. The clinical inventory will be sent to all sites to inform providers what clinical services are offered at which site so that they can make the best referral. 2. Make a checklist of items that a clerk will go over with the patient at checkout, including the question "Is this your preferred location for this treatment?" when options can be offered.
	8. Include a link on VAPAHCS website describing the basics regarding eligibility.	The Business Office has requested a web page on the VAPA Intranet Website. One of the references on the website will be the reference booklet titles "VA Healthcare Services 2000 Edition". It will address eligibility, registration and co-payment issues.
	9. Charter a PAT to improve all aspects of scheduling. Explore centralized scheduling for initial appointments and follow up.	Assigned to: Stephen Ezeji-Okoye and Jim Morrison

Fiscal Year 2000 – 2002 Strategic Goals (cont'd)

- Section 10: Strategic Goal 1: Be a Provider of Choice for Veterans

C. Improve VAPAHCS local and regional image	1. Improve internal marketing processes	(See Communication Section 6) - "Goal Sharing" initiatives
	2. Improve internal public relations.	(See Communication Section 6) – Town Halls at each VAPAHCS site
	3. Increase public exposure through increased use of public service announcements.	Communications Officer working with local media to gain media exposure
	4. Increase staff participation in local and regional professional and service organizations, I.e., AMA, County Medical Societies, Rotary, Lions, Elks, Masons, etc.	How to pay for annual dues/Set AA
D. Increasing Category A's	1. Develop Category A Task Force	1. Outreach coordinator has worked effectively to promote VAPAHCS services 2. "Goal Sharing" effort has been effective in gaining additional Cat As

Fiscal Year 2000 – 2002 Strategic Goals (cont'd)

- Section 10: Strategic Goal 2: Be an Employer of Choice

Objectives	Tactical Actions	Status
A. Provide a stimulating work environment.	1. Implement use of "learning maps" as a training and education concept and tool.	Learning maps training on One VA included in new employee orientation program and periodic classes offered to current employees throughout the year.
	2. Improve dependability and consistency of transmission of remote site training, I.e., grand rounds.	New videoconferencing equipment has been installed at all remote sites. The migration to the new videoconference standard (H.323) will be completed by the end of this fiscal year and will add even more speed (network speed) and reliability to these conferences.
	3. Explore outside training availability e.g., DeAnza computer training, community college tech training, etc.	For training that we cannot provide in-house and or training than can be provided more efficiently by an outside vendor, we make extensive use of outside training opportunities. Last yet we provided funding for a record number of outside training opportunities. We had also made use of outside resource for onsite learning. For example, with the need to bring our nurses up to BA level, we have relied on University of Phoenix program in the past and plan to use SJ State faculty to provide similar onsite training in the future. In addition, over the last 2 years we have renewed or modified affiliation agreements with over 170 other institutions. The number and scope of these affiliations change as need to meet the changing needs of VAPAHCS.
	4. Ensure that all employees obtain required TQI training.	Training will continue to be presented to employees during New Employee Orientation.
	5. Conduct assessment of effectiveness and usefulness of employee orientation training.	Quarterly review will be conducted by the QLT of employee evaluations of classes offered during new employee orientation.
	6. In collaboration with HRMS, develop an annual assessment of employee training in general.	Together with HRMS, we have conducted and reviewed employee training needs throughout VAPAHCS. This survey is conducted via VISTA and verbatim responses are summarized on a spreadsheet prepared by HRMS. The results are then condensed to reflect recurring issues raised by employees. These recurring educational themes are shared with the education committee and appropriate service reps. Our response has been to refer employees to existing computer courses, purchase 3 modules teaching interpersonal skills and we are comparing services that summarize recent advances in pharmacotherapy.
	7. Apply for pilot status as Reinvention Lab to achieve freedom from OPM requirements.	Meetings will be established with Bay Area VAMCs to identify what pilot initiative will be developed and submitted for VACO/OPM review. Written pilot proposal will be mailed to VACO/OPM for consideration.
	8. Develop a centralized calendar for all facility training.	Insert in organizational newsletter. Include calendar of training. Implemented in FY01 as a "Pull-out" to every newsletter – *The Epicenter.*

Fiscal Year 2000 – 2002 Strategic Goals (cont'd)

- Section 10: Strategic Goal 2: Be an Employer of Choice

B. Remove barriers to working effectively.	1. Develop expanded opportunities for flexible tours of duty.	1. Health Care System Memorandum No. 0598-03(tour of duty) has been issued. This HCSM provides for service level approval of tours of duty as well as alternative work schedule. 2. Health Care System Memorandum No.05-00-02 (Adjustable Work Hours For Part Time Physicians) has been issued. The HCSM provides for adjustable tours of duty for part time physicians. 3. Health Care System Memorandum No.05-00-04 (Alternative Work Place Arrangements) has been issued. The HCSM provides for flexi place or telecommuting for employees.
	2. Enhance health promotion programs for employees.	1. Health Care System Memorandum No. 11-90-02 (Smoking Policy) has been issued and provides for smoking cessation programs for employees of each division. 2.Health Care System Memorandum No. 05-00-09 (Employee Counseling Service Program) has been issued and provides counseling service (e.g., counseling and referral for problems dealing with emotional, personal, financial, marital, family situations, drug/alcohol, etc) 3. Health Care System Memorandum No. 05-97-12 (Employee Health Policy) has been issued and provides for health services for employees. 4. A Prevention Health Committee has been established to identify and develop new health service programs for employees. 5. Establish employee fitness centers
	3. Develop a scholarship program for childcare.	A memorandum of understanding between VAPAHCS and Whistle Stop Development Center was signed on 22 December 1999, whereby $10,000.00 in recycling funds will be used to provide financial aid for VA employees for childcare purposes.
	4. Implement computerized/electronic methods over paper methods including computer based over paper based training materials and report on accomplishments.	1. HR Links will be fully implemented as rolled out by VACO. 2. BCMA will be fully implemented. 3. CPRS will be expanded at all sites. 4. Web-based training (i.e. electronic forms, information, etc) will be made available.
	5. Promote Idea Program	1. Bulletins/articles/posters published to inform. employees of Idea Program and its significant accomplishments. 2. Review of current Health Care System Bulletin (HCSB) undertaken and updated policy issued to invigorate the program. 3. Monthly meetings to discuss and review employee ideas.

Fiscal Year 2000 –2002 Strategic Goals (cont'd)

- Section 10: Strategic Goal 2: Be an Employer of Choice

C. Enhance occupational safety programs.	1. Update facility emergency preparedness plan to ensure consistency with VHA and network mission goals.	Complete and publish manual.
	2. Develop system for recognizing contributions of service safety coordinators.	We have developed a training program for the approximately 100 Safety Coordinators presently active within the Health Care System. We have the training including favors, awards and lunch twice a year. The coordinators are very appreciative of the program. During the program we focus on the positive contributions of the service and area safety coordinators and how the VAPAHCS safety program could not function without them. However we recognize the need for additional rewards for employees willing to take on added responsibilities and plan to enhance the program.
	3. Better publicize the role and availability of the Ergonomics Committee and assessment capability. Track committee accomplishments and ergonomics requests.	Ergonomics committee implemented October 1999. Goals: 1. Early intervention and risk reduction of cumulative trauma. 2. Wellness and Health Promotion What has been accomplished: • Implemented a protocol for individual and work group ergonomic assessments. • Designated specific Occupational Therapists to the assessment process. • Continuously evaluated the procurement, storage, and distribution of ergonomics products from an approved standardized formulary. Wellness and Health Promotion Ergonomic Subcommittee Projects outcome: "Walking for Wellness" is a global health care system program. Program includes incentives for participation. This is a low impact safe exercise program to reduce stress and increase strength and endurance. Medical media produced campus mileage maps to help promote the program.
D. Develop effective communications at every level of the organization	1. Publicize major VAPAHCS committee minutes on DHCP and do the same for performance indicators developed by MIC.	Web page will be operational for publishing this information
	2. Associate Director and Chief of Staff will randomly attend service meetings and track monthly minutes.	Associate Director and Chief of Staff will Randomly attend service meetings and track monthly issues.
	3. Develop initiatives for enhancing the effectiveness of Service level staff meetings as a forum for encouraging communication and involvement of employees in quality improvement activities.	1. Training classes will be developed to train supervisors regarding effective communication techniques and elicit employee involvement at service meetings. 2. Managers submit actions taken as a result of employee suggestions - this is reported in management briefings.

Fiscal Year 2000 – 2002 Strategic Goals (cont'd)

- Section 10: Strategic Goal 2: Be an Employer of Choice

E. Improve employee morale.	1. Implement "employee of the month" program, I.e., reserved parking for 1 month.	HCSB outlining the policy, procedures and responsible officials for an employee of the month program will be issued.
	2. Develop a performance requirement for supervisors to reinforce importance of communicating/sharing information with subordinates.	HCSB on performance management for title 5 employees will be revised and updated to include a mandatory standard regarding communication/sharing of information with subordinates.
	3. Implement HPDM	HCSB developed outlining policy, procedures, and responsible officials for HPDM.
	4. Improve staff knowledge of upward mobility program.	HCSB published outlining the policy, procedures and responsible officials. Training class for supervisors conducted regarding job re-constructing for upward mobility creation purposes. Article in newsletter for employees regarding how the upward mobility program operates. Hispanic College/Advantage Scholarship programs. What are our upward mobility options?
	5. Continue the use of first line employee QLT membership application process on an annual basis.	Applications annually during the month of October.
	6. Continue the use of PATs as a method of improving VAPAHCS processes.	VAPAHCS uses Process Action Teams as a method for improving processes where and when appropriate. This includes teams not chartered by the QLT.
	7. Encourage all levels of employees on PATs when possible and appropriate.	1. Information will be included in the service chief's management briefing. This will include the identification of the numbers and types of internal TQI initiatives that have been explored throughout the year. 2. Every service will have a standing internal TQI team to entertain service staff suggestions for improvement.
	8. Develop a methodology for rewarding specific/key employees who contribute to facility performance that exceeds established performance measures.	Implemented Incentive Awards Program - HCSM No. 05-99-08 Publish award recipients in VISTA.
	9. Explore legality/feasibility of developing pre-tax accounts for childcare costs.	Report to ELB regarding options, if any, to create pre-tax accounts for childcare cost purposes.
	10 Recruit for new graduates and develop talent through mentoring programs.	HCSB outlining policy, procedures and responsible officials for a mentoring program issued. Training class conducted to train supervisors regarding mentoring skills.
	11. Implement Goal Sharing program.	Plans due back to Acting Director's Office
	12. Examine simplifying the new classification delegation.	Workgroup established to look at current delegation process and identify strengths and weaknesses. Recommendation to Director through ERB for suggestions designed to simplify the delegation process. HCSB on position classification reissued to incorporate program improvements issued.
	13. Explore creating a Delegating-examining unit in VISN 21 or at VAPAHCS.	Meeting with VISN 21 Personnel Officers to discuss feasibility of establishing VISN 21 Delegated Examining Unit. Report to Network Director and Facility Directors issued.

Fiscal Year 2000 – 2002 Strategic Goals (cont'd)

- Section 10: Strategic Goal 3: Be a Fully Integrated VA Health Care System Providing a Full Continuum of High Quality Care to Veterans

Objective	Tactical Actions	Status
A. Ensure appropriate referral access to secondary and tertiary care.	1. Develop a more consistent policy for receiving and processing internal and external patient referrals.	Improvement of Coordination of Transfers. 1. Business office to help determine insurance status of millennium bill patients. 2. Conceptual single point of contact plan will be developed. 3. A single number will be established as the only point of contact for referral questions 4. Hiring and training of staff to triage calls to medical or psychiatry. 5. IRMS to develop/install technological equipment to support this plan. 6. This single point of contact phone to be distributed and advertised. 7. Operators need to be made aware of this new number.
	2. Develop a single point of contact for all types of external patient referrals, including medical, surgical and mental health.	1. Implement single point of contact phone line plan (outlined above.
B. Be the VHA tertiary care referral center of choice.	1. Examine all referral programs' contribution or potential contribution toward being the referral center of choice.	1. Assess the needs of high cost, low volume services and county medicine/surgery within the VISN and local DOD county facilities. 2. Determine the capacity of our system to provide resources needed, if any, to meet actual demand. (Implementation depends on the results of the cost: benefit analysis of the Business Plan)
	2. Ensure transfer coordination process is seamless and easy.	1. Determine the need for specialty expansion. 2. Allocate the resources necessary (infrastructure is in place to proceed). 3. Negotiate with TRICARE and other VA's
	3. Maintain and expand existing STS programs and centers of excellence.	1. Determine the efficacy and needs of existing STS's and current Centers of Excellence. 2. Identify areas of expansion needed. 3. Negotiate with Foundation Health for individuals covered by DOD health care. 4. Develop outcome measures to determine that quality is maintained.
	4. Develop new STS programs.	1. Determine the need for STS expansion. 2. If applicable, negotiate new contracts with DOD and other VA needs to see if our current resources are sufficient. 3. Determine if our STS provisions are what other VAs and DODs need.
	5. Improve inter-hospital access to records	1. The telecommunications Infrastructure Project (TIPS) will be completed and will provide wiring to all VAPAHCS sites. 2. The lease of new PC Systems for all VAPAHCS sites. Develop the ability to share patient information via computer throughout the VISN.

Fiscal Year 2000 – 2002 Strategic Goals (cont'd)

- Section 10: Strategic Goal 3: Be a Fully Integrated VA Health Care System Providing a Full Continuum of High Quality Care to Veterans

	6. Implement IHI pain management program.	1. Reduction of severe pain for med/surg inpatients who score 7 or higher. 2. 100% assessment of pain for patients who report 4 or higher on admission. 3. A plan of care for all patients who report pain level of 4 or more and state they are dissatisfied with their pain level. 4. Patient education information regarding pain will be available in all outpatient clinic sites. 5. A hospital pain policy will be put into place 6. Staff education will be assessed and an education plan implemented. 7. Limit the use of Demerol
C. Develop a single coordinated, cost effective Home Care Program that meets patient needs both locally and at VISN levels.	1. Consolidate all home care programs under one organizational entity.	Because of the extent of the administrative structure this plan would affect, recommend to be tabled until a permanent Director and COS are in place.
	2. Explore feasibility of expanding access to home care to entire VAPAHCS catchment area.	1. Expand HBPC to Monterey (based at Monterey clinic)
D. Maintain or improve current JCAHO scores and become a contender for the Carey Award.	1. Develop a facility strategic plan and update annually.	First update due 12/31/00. 2nd update due 3/31/01. 3rd update due 6/30/01. 4th update due 9/30/01
	2. Re-engineer current leadership information/decision making forums.	By March 2001 -Review purpose/membership of committees beginning with EC, ERB,MEB and Equipment Board
	3. Insure ORYX measures meet performance standards and EPRP is greater than 90%.	ORYX measures continue to meet standards and are at a stable positive trend. New measures have been introduced this year (2001) with CHF and based on our baseline data, we are in a good position to meet standards and also have some opportunities for improvement not yet determined. EPRP sample methodology has changed this year and nationally all scores have dropped. This is not a negative reflection on care given but a direct result of changes in the population sampled. The Fully Successful score for PI is 78 and we expect to meet that and possibly exceed to exceptional.
	4. Improve provider education on ORYX measures and clinical performance measures.	Education on ORYX measures has begun with the Executive Council and with the Ambulatory Nursing Staff. Home care and LTC have been educated and are continually monitoring performance. During the first six months of 2001, front line staff education will begin.
	5. Apply for Carey Award in 2001.	Based on assessment report, application is being refined and will be submitted on application date, 20 March 2000

Fiscal Year 2000 – 2002 Strategic Goals (cont'd)

- Section 10: Strategic Goal 3: Be a Fully Integrated VA Health Care System Providing a Full Continuum of High Quality Care to Veterans

E. Achieve excellence in long term and end of life care for veterans.	1. Program NRM funding to enhance physical environment of care in Bldgs 331 and 90.	Building 331 is undergoing renovation to 331C (Phase I). This phase will be completed around March 2001. The second phase that includes 331B and 331D will start shortly after. The oxygen project is in the design phase for Bldg 331 and is planned to start as part of Phase II. The work on Bldg 90 is in the design phase with construction to begin late FY01 or early FY02. (Funding approved!)
	2. Develop a clear Community Nursing Home Care Program policy.	This policy has been written for both this facility and the VISN. VISN approval is expected within the next several months.
	3. Provide additional "end of life" training to providers.	The Hospice program now offers monthly educational programs for end of life care that is open to all staff. They have developed a Consultation team that responds to referrals at all 3 divisions. Further enhancement of these educational programs are anticipated with the arrival of a Hospice Fellow

Fiscal Year 2000 – 2002 Strategic Goals (cont'd)

- Section 10: Strategic Goal 4: Be Operationally Efficient and Increase External Revenues

Objective	Tactical Actions	Status
A. Increase annual external revenue collections to $30M	1. Hire a full time contracting officer to lead revenue generation planning and execution	Contracting officer hired
	2. Assess/re-engineer all MCCF processes.	MCCF Steering Committee assessing process improvement and billing and collection
	3. Establish process to monitor front-end information collection.	
	4. Negotiate contract for payment from HMOs	List of major HMOs have been developed and contact being made to explore contract opportunities. Revenue generation committee is tracking monthly progress Using ECG and Health Plus to establish contacts with HMOs
B. Achieve 5% growth in ambulatory care market penetration.	1. Allocate resources to meet demand in central valley and other sites as applicable.	Establish CBOC in Sonora.
	2. Evaluate effectiveness of TRICARE/DOD sharing agreements.	
	3. Centralize/coordinate Outreach efforts.	Recruiting
C Develop/implement compliance program.	1. Hire a full time compliance officer.	Completed
D. Develop a comprehensive strategic and capital asset planning process.	1. Update facility development plan by December 2000	A CARES (Capital Asset Realignment for Enhanced Services) contractor has been selected to study all Network facilities beginning March/April 2001. Initial information gathering has begun in terms of the Facility Condition Assessment (FCA) and the Space & Functional Surveys.
	2. Improve facility project design development process. Provide more information on initial stages to improve planning.	PHASE I (Scope definition and project approval phase) 1. Project application. Word format completed. A web-based application is planned for the future. 2. Station Policy. Draft Completed. 3. The new application identifies all costs (Design, Const, Activation, Impact). The policy establishes a project scope and requires setting a cost target and will provide a scoring (Prioritization) methodology. The prioritization methodology is in draft form. PHASE II (Design Phase) 1. Design Team is in place. We need to formalize "Design Team Responsibilities." This will include developing a phasing schedule, dominos projects or moves, bid alternates
	3. Develop capital investment proposal(s) for seismic corrections of buildings 2, 4, 23, 40, 137 & 205.	1. Building 2, Submitted Major project application, 4/12/00. 2. Buildings 23/40, Approved for FY01 Minor Const. design. 3. Buildings 4/205, Preparing Project Application for March 2001 deadline. 4. Building 137, Planned for FY02/03 Minor Design/Const
	2. Install new PCs at Menlo Park and Livermore and selected sites at Palo Alto.	Lease of new PC Systems for all VAPAHCS sites.
	3. Complete TIPS project.	The telecommunications Infrastructure Project (TIPS) will be completed and will provide wiring to all VAPAHCS sites.
	4. Complete Wide Area Network.	The VISN Wide Area Network (WAN) project will be completed in January of 2001. The project will add high-speed connections between all VAPAHCS sites
E. Optimize use of consolidated contracting.	1. Examine all contracts or potential consolidated contracting.	A&MMS and Commodity Standards Committee working collaboratively with VISN, Consolidated Contacting group to maximize opportunity for volume discounts through consolidated contracting.

Fiscal Year 2000 – 2002 Strategic Goals (cont'd)

- Section 10: Strategic Goal 5: Continue Excellence in "Special Emphasis" Programs and Services

Objective	Tactical Actions	Status
A. Improve access to care.	1. Develop a uniform Network workload reporting system to facilitate analysis and allocation of resources for special emphasis programs.	
	1. Continued	Look into installing Omni-cell at all special emphasis programs. Currently this is only at SCI because of the financial effectiveness (i.e., turnaround of money received vs. resources used). Ask for VISN funding to support the use of Omni-cell on all special emphasis programs. This can then be used as a tool for comparison amongst all special emphasis programs.
	1. Continued	Collect the following information from each program: Number of patients seen (inpatient and outpatient)
	2. Publicize availability of "special emphasis" programs.	
	3. Improve process of integrating the transition from inpatient to outpatient care and necessary follow-up, including telemedicine initiatives.	1. Gather information from the system of inpatient case managers on surgical and medical wards and managers of outpatient clinics regarding their view of how to improve the process. Speak with the constituents (nurse managers, physicians, case managers, etc.) of other inpatient programs about their needs. 2. Survey the current state of affairs on each of the inpatient wards and see what their problems are. Formulate plan based upon findings from the surveys.
	4. Establish a seamless referral process for special emphasis programs.	Same as above
B. Achieve CARF accreditation where applicable.	1. Survey SCI for CARF accreditation in December 1999.	Already accredited
	2. Survey CWT for CARF accreditation in 2001	Application will be submitted in 2001 (subject to changes in program or support)
	3. Re-survey PM&R and TBI in 2000	Survey to be accomplished in 2001
	4. Apply for CARF accreditation for WBRC in FY2001.	No standards yet set for WBRC in CARF accreditation.
C. Enhance treatment programs for women.	1. Develop seamless, team based system of health care delivery for female veterans.	1. Expand clinical reminders to increase ease and number of referrals from other providers to women's health programs. 2. Incorporate skeleton guidelines on women's conditions into GUI as appropriate. 3. Inform all providers as to how to order mammograms to improve screening rates. 4. Update the mammogram brochure. 5. Adjusted encounter forms to include expanded reminders (e.g., osteoporosis, domestic violence, urinary incontinence screening, hormone replacement therapy. 6. Letter sent to providers with guidelines regarding this additional reminder.
	2. Enhance mental health programs for women.	1. Inform all MH providers to refer all female veterans to Primary Care. 2. Inform all VAPAHCS providers of outpatient mental health services available to women veterans.

Fiscal Year 2000 – 2002 Strategic Goals (cont'd)

- Section 10: Strategic Goal 5: Continue Excellence in "Special Emphasis" Programs and Services

D. Improve communication/coordination among special emphasis programs.	1. Develop a forum for Special Emphasis program leaders to meet regularly.	
	2. Develop educational program for house staff on special emphasis programs.	

Fiscal Year 2000 – 2002 Strategic Goals (cont'd)

- Section 10: Strategic Goal 6: Continue Excellence in Growth in Research, Training, and Education

Objective	Tactical Actions	Status
A. Increase research revenue base.	1. Continue effective collaboration with PAIRE.	Will continue to meet on regular basis and to develop strategic plans together.
	2. Maintain flexibility for providing space to support attractive new research programs.	Will continue to follow space assignment policies refined in HCSM 151-98-04 Allocation of Research Space; will continue to pursue opportunities to renovate space as required for new programs.
	3. Pursue a change in VAHQ policy such that salary support would be provided in all research grant awards.	Will continue ongoing negations with HQ on this topic. May not be most advantageous to have salary provided directly, so will continue to analyze ramifications on this policy
B. Expand training and education opportunities.	1. Explore all sites for appropriateness for use as a residency training/education site	Currently, VAPAHCS has a number of in-house and off site educational opportunities. We have augmented our on-site conferences, in-services and flexibility to adjust to the learning needs of our employees.
	2. Expand and improve V-tel usage.	IRMS is working with both the clinical and administrative staff to advance the use of videoconferencing technology for educational purposes. Many new training conferences have been established.
	3. Explore additional new technologies, I.e., web based training.	The Information Management Council has formed a subcommittee to work on the development of an Intranet Web page for the VAPAHCS. The page went on line in September of 2000. The committee will help coordinate many uses of the Web page including educational opportunities.
C. Improve resident satisfaction.	1. Continue use of resident satisfaction survey.	Network goal is 90%. Currently score is 97%. Survey administered quarterly.
D. Become the training site of choice.	1. Promote increased interest in available training opportunities and resources.	
	2. Develop a marketing program for training opportunities.	Resurrect annual training booklet and put on web page

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